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# OVERSIGHT OF SOCIAL SECURITY DISABILITY BENEFITS TERMINATIONS

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## HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT OF GOVERNMENT MANAGEMENT

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

MAY 25, 1982

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# OVERSIGHT OF SOCIAL SECURITY DISABILITY BENEFITS TERMINATIONS

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TUESDAY, MAY 25, 1982

U.S. Senate,
Subcommittee on Oversight of
Government Management,
Committee on Governmental Affairs,
*Washington, D.C.*

The subcommittee met at 9:35 a.m., in room 1318 of the Dirksen Senate Office Building; Hon. William S. Cohen (chairman of the subcommittee) presiding.

Present: Senators Cohen, Pryor, and Levin.

Staff present: Susan M. Collins, staff director; Rebecca Amsden, professional staff member; Frances C. deVergie, chief clerk; Rachel Harlan, assistant chief clerk; Linda Gustitus, minority staff director and chief counsel to the minority; Barbara D. Savage, minority counsel; Susan Unsworth, congressional fellow; and Todd Varon, intern.

## OPENING STATEMENT OF SENATOR COHEN

Senator Cohen. The Senate Oversight of Government Management Subcommittee is conducting this hearing to examine actions taken by the Social Security Administration to determine the continued eligibility of individuals receiving disability benefits.

This hearing was suggested by the subcommittee's distinguished ranking minority member, Senator Levin, after his staff conducted a study of claimants who had had their benefits terminated under the new accelerated investigation process being used by the Social Security Administration.

The subcommittee determined that the problems which Senator Levin had identified were not unique to the claimants in Michigan but, rather, were prevalent throughout the country. Under our current laws, in order to qualify for Social Security disability benefits, a worker must meet very stringent criteria; he must be so disabled that he not only cannot perform the work that he had been doing, but cannot engage in any kind of substantial gainful work which exists anywhere in the country.

In 1980, at the behest of the Carter administration and in response to studies by the General Accounting Office, Congress passed legislation which mandated the Social Security Administration to conduct continuing disability investigations of individuals with nonpermanent disabilities every 3 years.

These periodic reviews are intended to insure that only those who are truly disabled and unable to work continue to receive benefits. In light of the escalation in the cost of disability benefits, such investigations, in my judgment, are absolutely essential to preserving the integrity of the program.

Congress directed the Social Security Administration to begin these reviews in January 1982 in order to allow time to establish the necessary procedures and to hire and train additional staff to insure that the reviews would be conducted efficiently and fairly.

The Social Security Administration, however, moved the date up for the beginning of these reviews to March of last year. Between March 1981 and April of this year, State disability determination units reviewed more than 430,000 cases sent by the Social Security Administration for continuing disability investigations. Benefits have been terminated in more than 40 percent of the cases, far above the 20-percent rate originally predicted by the Social Security Administration and by the General Accounting Office.

In the State of Maine alone, benefits for more than 1,000 individuals have been terminated since the accelerated review process began, despite the fact that, in many cases, the claimants still appear to be severely disabled and unable to work.

We have received similar reports from all over the country of truly disabled individuals being dropped from the program. A disturbing pattern of inadequately documented reviews, incomplete medical examinations, misinformation, and erroneous decisions has emerged. We have discovered that the claimant's medical history is sometimes disregarded in making the decision on his present disability, and that beneficiaries often do not understand that they must again prove their eligibility for the program.

If an individual is mistakenly eliminated from the program, he can appeal the decision and his chances of eventual reinstatement are rather good. In fact, the administrative law judges who hear appeals from claimants are reversing the cessation decisions for over 60 percent of the individuals who now appeal.

But the road to reinstatement is very arduous and lengthy; and in waiting for a final decision, the claimant may be without benefits for many months, due to the tremendous backlog of cases. Many individuals have been forced to turn to welfare, since their disability benefits have been their only source of income.

Since Congress mandated these reviews, but failed to establish specific guidelines for selecting cases and conducting the investigations, I believe that we in Congress share a measure of responsibility for the problems that have occurred.

I want to emphasize that the principle of regular reviews of eligibility, I believe, is a sound management tool. It's necessary to identify people who are no longer disabled and in need of assistance.

The Federal Government spent more than $17 billion last year to provide benefits to disabled workers, their spouses, and their children. Unless we eliminate from the program those individuals who no longer require this assistance, we limit our ability to provide fully for those who urgently require our help.

So, our purpose today is to examine the serious problems that have arisen during the course of these investigations, and to seek solutions for them. We need to determine why truly disabled people are being removed from the program; why the appeals process is so slow; and whether State disability units are being provided with enough resources to conduct these investigations.

Our goal is a review process in which claimants clearly understand their responsibility to reaffirm their disabilities, and in which the investigations are conducted fairly and efficiently to prevent needless suffering for the truly disabled.

I look forward to hearing our witnesses today. But before I do, I would like to yield to the Senator from Michigan, Senator Levin.

## OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. Thank you, Senator Cohen.

First, let me commend you for your fine leadership of this subcommittee.

Today we are investigating a system that is in shambles. It is in shambles because it's on overload and it can't take it. In the course of its sinking, it's taking the lives and the hopes of thousands of Americans with it.

The social security disability system is a promise to working Americans who contribute to and support the system that they will be protected in the event of accidental injury or serious physical disease or mental disorder, conditions that can befall any one of us, without our control.

Yet this promise, or protection, has really turned into a nightmare of sorts, with allegations and complaints pouring in from all over the country, that truly disabled people are being terminated from the disability program, inappropriately and arbitrarily.

Why? Because what we thought was a good management idea—and I emphasize that everyone thought that, this is not a partisan issue—turned out to be more than the social security system could handle. And instead of saying, "Stop. We can't do it yet," the Social Security Administration shuffled these cases out to the States for review.

We in Congress were equally responsible for this—superficially responsible—meaning that we have done nothing to bring this injustice to a halt.

In 1980, Congress amended title II of the Social Security Act, requiring review of each disability case every 3 years. The reviews were to begin in 1982, to allow social security to prepare for the dramatic increase in the workload. Prior to 1980, 160,000 cases were reviewed in any 1 year; in 1981, some 351,000 additional cases were reviewed; and it is estimated that 567,000 cases will be reviewed in 1982, and 840,000 cases will be reviewed in 1983. That's over a 368-percent increase, just between 1980 and 1983.

Of course, reviewing each disability case every 3 years seems to be the right thing to do. No one wants someone collecting disability who isn't disabled; but that's not what we're hearing about the persons who are being terminated. Many of these people are still severely sick with definite disabilities, and cannot now—and perhaps will never be able to—secure substantial gainful employment. For every one weed that social security is plucking, it is crushing two flowers, if the reversal rate by administrative law judges is any indication.

There are eight cases that we know of in our office where individuals committed suicide apparently because they were either terminated or were denied social security disability benefits. My Michigan office has informed us that the case load for disability review has increased threefold in the last year, and I know that is not unique to Michigan, as the chairman has indicated.

We have hundreds of files, from across the country, of individuals complaining about the injustice of the disability process and the decision to terminate their benefits. Part of this is because the administrative history of the disability insurance program is plagued by serious structural and managerial failures, all too well documented in a litany of critical reports and investigations by the House Ways and Means Committee, the General Accounting Office, and the National Commission on Social Security, to name a few.

It is also due, in no small part, to the fact that in March 1981, social security, at the urging of the Office of Management and Budget, decided to initiate this stepped-up review process 1 year earlier than mandated by Congress, in an attempt to save some $200 million for fiscal year 1982.

What we should remember about the disability program is that it is not a charity program, it is not a handout. Each worker pays for his or her right to be protected. He or she pays every time they collect a check, with a little taken out to contribute to the social security disability trust fund. It is because of this fact that the injustices here are even more disturbing.

The disability review process allows for a determination by the State agency of the claimant's existing disability. If that is denied, the claimant receives reconsideration by the State agency. If that is denied, the claimant can appeal to the administrative law judge. Presently, the rate of reversals since March 1981, by the administrative law judges, is 67 percent. That's an astounding rate of reversal.

The massive injustice occurs at this point because, from the time that the disability termination decision is made by the State agency, to the time that the administrative law judge issues a reversal, the claimant is not entitled to any benefits or medical insurance. That review by the administrative law judge, under this presently over-burdened system, can take anywhere from 9 months to 1 year.

During that year, the claimant is sick—and in today's markets, jobs are extremely scarce. So, of some 109,000 persons, between March 1981 and April 1982, whose benefits were terminated, half of those persons will appeal the termination decision to an ALJ, an administrative law judge; and 67 percent will be reinstated. That's 36,000 people who have to go without disability income for anywhere from 9 months to 1 year when, in fact, they never should have been terminated in the first place.

If that reversal rate continues, that means that through 1983, social security will have terminated, and subsequently reinstated by ALJ's, 232,000 individuals. That's an unconscionable amount of financial and emotional hardship.

We should call a halt to this debacle now. We in the Congress and the Social Security Administration should admit that we have made a mistake. Requiring reviews is fine; it's appropriate. But not unless, and until, there is a fair system in place. We have either got to stop these new reviews until there is such a system developed, or allow beneficiaries to receive benefits through the review process—again, until we can straighten out the system.

There are a number of bills before the Senate containing specific remedies, including Senator Metzenbaum's bill, Senate bill No. 2086 and a bill which I introduced as Senate bill No. 1944.

Let me again emphasize, this is not a partisan issue. The issue isn't whether the blame lies in the Carter administration or the Reagan administration; nor is the issue whether the fault lies with the executive or the legislative branches.

The issue is: Is there a problem? And what is the cure?

I look forward to the testimony of today's witnesses, and again want to commend Senator Cohen for holding these hearings.

Senator COHEN. Thank you, Senator Levin.

Our first witness today is Paul Simmons, Deputy Commissioner for the Social Security Administration.

Mr. Simmons, will you take the opportunity to introduce the people that you have brought with you today.

## TESTIMONY OF PAUL B. SIMMONS, DEPUTY COMMISSIONER FOR PROGRAMS AND POLICY, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY BEVERLY A. BEDWELL, ASSOCIATE COMMISSIONER, OFFICE OF ASSESSMENT; DONALD A. GONYA, ASSISTANT GENERAL COUNSEL, SOCIAL SECURITY DIVISION, OFFICE OF GENERAL COUNSEL; RHODA M. GREENBERG, DIRECTOR, OFFICE OF DISABILITY PROGRAMS, OFFICE OF OPERATIONAL POLICY AND PROCEDURES; AND LOUIS B. HAYS, ASSOCIATE COMMISSIONER, OFFICE OF HEARINGS AND APPEALS.

Mr. SIMMONS. Thank you, Mr. Chairman.

I do appreciate this opportunity to appear before this subcommittee today. I am accompanied this morning by Ms. Beverly Bedwell, Associate Commissioner of the Office of Assessment; Mr. Don Gonya, who is our Assistant General Counsel of the Social Security Division; Ms. Rhoda Greenberg, Director of the Office of Disability Programs; and Louis B. Hays, Associate Commissioner of the Office of Hearings and Appeals.

I hope among us we can answer any questions that you may have on the problem—and you are right; we do have a problem.

From the inception of the disability benefit program in 1956, the definition of "disability" has always been very strict, and can only be met by the very severely disabled. Partial disability, which is recognized in many other benefit programs, is not sufficient for social security benefits. The Social Security Act provides that a claimant's impairments must be so severe that he is not only unable to do his previous work, but cannot—taking into consideration his age, education, and work experience—engage in any other kind of substantial gainful work which exists in the national economy.

So long as this work exists in the national economy, it does not matter in the eyes of the law whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him or her, or whether he or she would be hired if he or she were to apply for work.

The disability must be expected to result in death, or must have lasted, or be expected to last, for a continuous period of 12 months or more.

This is the statutory language, not SSA's interpretation of the statute. And that's subject to a lot of misinterpretation.

The same definition of "disability" applies not only to those initially filing for benefits, but also in determining whether beneficiaries should remain on the rolls. The original definition of "disability" for social security was even more severe than the present one. It required that the impairment be expected to result in death, or to be of long-continued, and indefinite duration.

The present definition was adopted in 1965, at which time the Congress indicated that it expected SSA to review the condition of beneficiaries periodically, to assure prompt termination when a beneficiary ceased to be disabled.

However, aside from statutory changes in the definition, advances in medical science have resulted in many de facto changes. Due to the availability of kidney transplants, bypass surgery, and new medications for mental impairments, for example, certain medical impairments which were permanently disabling in the past may not be disabling today. Thus, medical advances may require changes in continuing disability investigation (CDI) procedures, since people considered permanently disabled when they came on the rolls 10 to 15 years ago may no longer be disabled in the eyes of the law, and in view of the advances in medicine and therapy which were not even thought of as recently as 10 to 15 years ago.

In addition to liberalizing the definition, Congress has made other eligibility requirements for disability less restrictive. For example, the insured status requirements were liberalized twice.

A number of occurrences in the 1970's raised concerns about the program. While the program grew relatively slowly during the 1960's, it began to grow rapidly during the 1970's. In fiscal year 1969, for example, the Social Security Administration received 700,000 claims for disability benefits; by 1974, the number of claims per year had grown to over 1.2 million.

Part of this growth can be attributed to adverse economic conditions, but much of it was contributed to by program liberalization.

In addition, over 500,000 claims under the black lung program, which started in 1970, had been filed over a relatively short period of time; and SSI disability claims added almost another 1 million claims a year, after that program's implementation in January 1974.

The advent of these new programs requiring disability decisions put a strain on the disability process. The result was tremendous pressure to process claims quickly and reduce the backlogs. At the same time, there was an effort to hold down processing costs, which produced a conflict between quality and quantity.

By 1975, these factors resulted in the highest disability incidence rate in the history of the program. There were 7.1 disabled worker beneficiaries per 1,000 workers. While disability incidence has fluctuated widely over the years, the rates of sickness and injury have not changed appreciably in the general economy—only in this program.

Currently, the social security trust funds are running a deficit that mounts by $17,000 per minute, and 44 percent of that total, we believe, can be attributed to the payment of disability benefits to those who are not disabled under the letter of the law.

As incidence rates and costs increased, concerns began to be expressed about the quality of administration of the disability program. In 1979, as you know, both the Carter administration and the Congress made recommendations for improving the administration of the program and cutting its costs, culminating in the Social Security Amendments of 1980.

These amendments contain provisions aimed at restraining the costs of the program, improving work incentives, and improving administration. Among the latter was the provision for periodic review of the social security disability rolls.

Social security has always reviewed disability cases to assure that beneficiaries' disabilities are continuing. However, before the periodic review process was enacted in 1980, mandating that we review all of the people on the rolls, only certain kinds of cases were reviewed: those in which the medical condition was expected to improve in a short time, those in which the earnings record indicated work activity was recommencing, and those in which a beneficiary voluntarily reported work activity or medical improvement.

In recent years SSA as an administration began to question whether the CDI process was adequate. It was clearly not designed to identify cases in which the initial determination of disability was incorrect or those in which, because of statutory changes and medical advances, the impairment might no longer be considered disabling. Also, only a small percentage of those cases in which improvement could be expected was being reviewed.

Congress was also obviously concerned, and I might add, the General Accounting Office was particularly concerned over the years, as Mr. Ahart points out in the testimony he has submitted for the record of this hearing.

I mentioned that in 1980 the Congress moved to enact periodic review requirements. This provision requires SSA to review all nonpermanent disabilities at least once every 3 years and permanent disabilities at such times as the Secretary considers appropriate. This legislation required that SSA begin the periodic review in January 1982.

As it turns out, the concerns which led to enactment of that law were well founded. In fact, the situation was even worse than we had imagined. A 1981 GAO report indicated that as many as 584,000 beneficiaries, or about 18 percent of the disability rolls, did not meet eligibility criteria. The report pointed out that the cost to the trust fund of incorrect payments at that time could be as much as $2 billion per year. Later data are even more alarming. A special SSA review of 24,000 cases—representing about 60 percent of the beneficiary population on a sampling basis—indicated that 33 percent were not truly disabled under the definition of the law.

Another special Social Security Administration review of a statistically valid random sample of 2,800 cases—representing the entire rolls—indicated that perhaps 30 percent were not entitled to benefits, and based on this study, we were able to determine that as much as $4 billion is now being paid out annually to people who are not disabled, a payment error rate of more than $1 out of $4 spent on this program.

In light of findings in the GAO and SSA studies that huge sums of benefits were being paid incorrectly, the Administration decided not to wait until 1982 to accelerate the periodic review process mandated by the Congress, and I might add that in the month we began that review, March 1981, 10 months early, GAO formally issued a report which told us or urged that we redirect existing resources to do precisely that, to start earlier. It was not an OMB creation. It was a combination of OMB and the Administration responding to great pressures that we were getting from both within and from without and from the GAO.

The decision to go, we believe, was prudent, even administratively. If we had waited until January 1, 1982, we would have had to process 800,000 CDI's in a 9-month period. Instead, by starting in March 1981, we had 18 months in which to spread this workload. The Administration's decision to accelerate the review of the disability rolls was fully supported with appropriate staffing and other necessary resources. In fiscal years 1981 and 1982, we significantly increased staffing and funding for the State agencies which make disability determinations for SSA in initial and reconsideration cases, including CDI's.

Total State agency staff increased 33 percent between fiscal year 1980 and 1982, while funding increased 64 percent for the same period.

The staff of the Office of Hearings and Appeals which has responsibility for the adjudicatory hearing process, also increased 12 percent and funding levels for OHA rose 36 percent. There have been States where there has been a problem, because of gubernatorial hiring freezes and so forth. I believe you will hear from a representative of one of those States this morning. I experienced that myself when I was in Illinois State government. There have been problems along that line, but by and large the States have, indeed, staffed up; and I think almost all the large states are fully staffed and meeting the targets, and I think the processing times that we are experiencing out there now demonstrate that.

I think it's important to note at this point that this year we estimate that the Social Security Administration will spend over one-half of our entire administrative budget just to run the social security and supplemental security income disability programs, and those two programs account for only 17 percent of the benefit population that we serve. More than half of our resources being devoted to one in six of our beneficiaries, indicates, I think, the degree of interest and the degree of dedication we have put into this program.

I'd like to point out that the entire disability review process and adjudicatory process that we have is really a four-level field process. It is probably the most extensive of any program in the State or Federal Government and designed by the Congress and preceding administrations precisely to help people find justice in a system that may or may not give them justice. This is a unique system to have four levels of appeal, including to the Federal courts.

I would like to discuss the CDI process in terms of three general areas: the impact on claimants and beneficiaries; the quality of the review process, which I know is a great issue at this hearing; and the impact on the hearings process.

Since March 1981, when we began the CDI process, over 343,000 beneficiaries have had their eligibility reviewed and more than 139,000 have had their benefits terminated. The process has affected new claimants for disability benefits also. Overall, State agency processing times rose from 44.6 days in the first quarter of 1981 to 50.3 days in the first quarter of 1982, and I would submit, from an administrative point of view, that that kind of an increase, given the volume of new work coming in, indicates that the States by and large have been able to reach adequate staffing levels. While the processing times have increased, the accuracy rate for initial State agency terminations has improved somewhat. Some of the increase in processing time, I should also mention, is due to factors such as the preparation of personalized denial notices as required under the 1980 amendments, and the requirement also that we have a physician's signature on medical evidence.

We believe that some of the adverse reaction to the CDI process stems from public misunderstanding of the fact that the periodic review process is mandated by law, and that the definition of disability under the Social Security Act is very strict. The adverse reaction of some disability beneficiaries to periodic review is also based on misunderstanding. Most beneficiaries were never led to expect that their cases would be reviewed again. In their own minds, they were retired permanently on the disability insurance program. As a result, terminated beneficiaries, obviously, have to make tremendous adjustments. And of course, current economic conditions, with unemployment high and jobs being scarce, add to their anxiety.

But I think it's important to note here that under the old process when we were reviewing only about 150,000 cases a year as opposed to the new process, where we're now going to be reviewing over 500,000 cases a year, the cessation rates are essentially the same. We had almost the same cessation rates under the old process. What's new now is the volume, and when a mistake is made, and mistakes are being made, as I will mention in a few minutes, the attention to that is understandable. We understand the attention to it, and we are certainly paying attention to it.

To monitor the performance of State agencies in making continuing disability decisions, SSA performs quality assurance reviews. This review involves a random sample of recent State agency decisions, and it is designed to determine the extent to which State agency decisions properly reflect the eligibility criteria in the law and in the regulations. Under this review, our most recent review, about 97.5 percent of CDI determinations in the 6-month period ending in March 1982 were found to be correct by our auditors; the figures were 97.4 percent for continuances and 97.6 percent for terminations.

I believe that this shows that the accuracy of the CDI reviews as measured under the terms of the law and regulations is very good. Of course, there is always room for improvement, and as I will discuss later, we are doing a number of things aimed at making these improvements.

Our hearings workload has also been increasing, and as a result, processing times have increased. Total hearing requests have increased from 136,000 in the first 6 months of fiscal year 1981 to 152,000 in the same period in fiscal year 1982. In March of 1982 alone, we received 31,000 requests, which is by far the most we've ever received in a single month. There has also been a slight increase in processing time for hearings. This is a national average, from 164 days in fiscal 1981 to 173 days as of April 1982. You may find isolated areas of the country where that processing time is running longer. You may also find individual cases that have dragged on for longer than the average. Obviously, the average is the middle ground, but nonetheless, we believe that number also indicates that we are moving to staff up to meet the growing workload.

For budget purposes, that means we are planning to have the people in place to handle this workload. We are projecting 328,000 requests for hearings in fiscal year 1982 and more than 400,000 in fiscal year 1983, compared to 281,000 in fiscal year 1981. This increase in hearing requests includes expected increases due to the CDI process; however, appeals are expected to level off quite sharply, once the program has gone through this 3-year cycle and we have completed our review of the existing disability rolls.

Lower level decisions are now being reversed by administrative law judges in approximately 60 percent of CDI cases, where people appeal their case to them. This, of course, raises the question, "If our quality appraisal shows a 97.5 percent accuracy rate for initial State agency decisions, why is the allowance rate at the hearing level so high?"

There are a number of factors which we believe result in allowances at the hearing level, including the subjectivity of the decisionmaking process, the face-to-face contact with the beneficiary that first occurs at the hearing level, which is an anomaly we want to correct, and I'll take that up later in this testimony, the possibility of progressive worsening of the claimant's medical condition during the course of the various reviews of the claim, and the fact that additional evidence may become available at the hearing level for the first time. However, to a large extent, we still believe the high allowance rate is due to incorrect decisions by the administrative law judges.

Under our program of own-motion review, as required by the Bellmon amendment, our Appeals Council is now reviewing 15 percent of administrative law judge allowance decisions. This review, mandated by the law, includes both initial claims and CDI cases. We are finding defects in 50 percent of the decisions we review. In approximately one out of every five cases reviewed, these errors are so substantial that the Appeals Council must either reverse the ALJ's decision or remand the case back to the ALJ for further action.

The Bellmon amendment, as you know, as the Congress intended when it was passed, is intended to get at the problem of ALJ's using different standards than the State agencies were being required to use. There's a lot of history to this—and I'll mention it a little bit later in this testimony—and there's a lot of misunderstanding about what is happening out there. The Bellmon amendment was designed to start to bring the two systems together, so that there's more cohesiveness, more commonsense in the way the standards are applied, and we believe that is going to happen, and we're looking to that Bellmon process and to other administrative steps that we are taking to help bring that about.

Now I would like to tell you about some of the actions that we have taken to improve the CDI process administratively. These improvements fall into three general categories: those intended to improve the overall process; those affecting quality control; and those which will improve the appellate process. I should add that the 1980 amendments pretty much dictate the general program we must follow in doing the CDI's. We have limited freedom under both those amendments and prior law to do much on our own other than what I describe here.

We also have a Commissioner, Jack Svahn, who is personally concerned, and who is moving as hard as he can to improve this program administratively, and some of the actions I'm going to outline here, I think, reflect that very well.

We are refining our selection criteria so that more beneficiaries who are permanently disabled are identified and exempted from this 3-year periodic review process. In March we identified several new categories of impairments which should be considered permanent, and as additional experience is gained, we expect to add additional impairments to the list. This will cut down on the number of reviews and will permit a more productive use of State agency resources and will, of course, reduce costs. Our regional offices are working with the State agencies to set up more effective internal reviews of error-prone cases. We are testing the use of multiple consultative medical examinations in certain cases, particularly those involving psychiatric impairments.

We have also begun a number of other initiatives to insure that the consultant medical examination process is fully and fairly administered, as I mentioned earlier, and as I will detail for the record in an appendix to my testimony.

Beginning in March, we began requiring that the States furnish more detailed explanations of termination decisions.

We are attempting to improve decisionmaking by physicians who are employed by SSA and the State agencies through special training, particularly training regarding the evaluation of psychological impairments and an individual's remaining capacity to work, and very importantly, we are moving to require that every State attempt to get all medical evidence of record for the past 12 months to be considered in the process, instead of the current practice of looking back only 3 months. This is a major issue that was raised by Mr. Ahart in his testimony, and we have moved administratively to do what he suggested in his testimony.

As part of our quality control process, we review a sampling of CDI cases after a decision has been reached to determine whether the disability is continuing or has ceased. To improve this procedure, we are taking two steps. In termination cases we are conducting the quality review before benefits are stopped. That is something new, and something we have done on our own. And we are doubling the number of quality reviews of termination cases from 13,500 cases annually to 27,000 cases annually.

Under the present law and the 1980 amendments, as you know, we are under the gun to review cases that are approved, not cases that are terminated. And there is a built-in psychological bias, obviously, in a situation like that. A State agency might disavow this, but an adjudicator may say, "We'll deny the case, because we won't be reviewed on that."

We're doubling the number of termination cases that we review, and we're asking the Congress in the bill which is now coming out of the Ways and Means Committee to give us express authority to reduce the number of reviews that we do of allowances and to concentrate more on disallowances, because we think it is incumbent upon us, if we are going to have a fair system, to take an evenhanded look at what's going on on both sides of the ledger, not just on the cost side.

In our quality review process, we are studying terminations to ascertain what kinds are especially error-prone and we are subjecting these kinds of cases to a more intensive review before a final decision is made. We hope this will enable us to prevent more of these errors that we're seeing, in the future. We are also studying the feasibility of doing initial development of CDI cases before they are released to State agencies for investigation, in order to eliminate additional permanent disability cases from the 3-year review.

The third area where we are making administrative improvement is in the appellate process. In general, we are determining that a disability has terminated as of the date the beneficiary is notified of the termination. This is a major issue and is addressed in the Ways and Means Committee bill. We moved administratively before that was even in the Ways and Means bill to do that. It didn't make sense to us to tell a person who had no reason to believe that he would ever be reviewed that now, under the 1980 law, he would not only lose his benefits but would have to repay 2, 3, or 4 or 10 years of benefits, because we can show that he actually recovered that long ago. We just didn't think that made sense, so the Commissioner, on his own motion, has determined that, unless it's a clear case of fraud, the person will be forgiven his past debt to the Federal Government. There's quite a bit of money involved.

We're hiring more than 100 additional administrative law judges this year, which will increase the size of the corps to 800. More important, we're also increasing the ratio of support staff for the ALJ's from the past level of approximately 4 to 1 to a ratio of 5 to 1, which is a 25-percent increase in the staff which will be available to help.

We're also giving priority in the appellate process to appeal requests in termination cases, and through improved training, upgraded equipment and new workflow and organizational arrangements, we are increasing the productivity of hearing offices, which means we are working to reduce the amount of time it takes to get a hearing at the hearing office. We've done all this administratively. We could do much more if Congress were to enact key provisions of H.R. 6181, which was approved by the Ways and Means Committee on May 19. On April 28, Secretary Schweiker and Commissioner Svahn announced the administration's strong support for certain provisions designed to build a 3-year transition period while the review of the existing disability rolls is being completed.

The administration supports, for example, permitting beneficiaries to continue to receive benefits until a reconsideration determination is reached and extending the time limit on reconsideration from the present 60 days to 180 days. That's a 4-month addition.

We also support legislation that would bring about face-to-face contact in the termination cases during the reconsideration process.

We firmly believe that if we were to do face-to-face reconsideration decisions on cases that were a close call after reviewing the written evidence, this would sharply reduce the number of incorrect decisions and would sharply reduce the workload on the ALJ's.

It will also protect people from having to go through a waiting period without benefits and go through all the rigamarole one has to go through. These two elements alone then would dispel two of the most anomalous provisions of the present law in practice. We are continuing to work with Congressmen on the technical aspects of this legislation, but we believe that overall the bill takes a constructive approach which is in line with our desire to improve the programs so that the disabled people who genuinely need help can get it.

This bill would also make improvements in three major areas that are still under discussion: benefit protection for terminated disability beneficiaries, an improved reconsideration process, and uniform standards for decisionmaking in all disability cases.

We are, by the way, doing administratively much of what this bill will do to create uniform standards, which is one of the thorniest areas that we have.

I'd like to skip over the next several pages of my prepared testimony and enter them for the record, if I could, and go to the conclusion with some added thoughts.

I would like to reiterate the fact that the periodic review process is part and parcel of our ongoing mission to insure that disability benefits are paid only to those individuals who meet the criteria established in the law.

This process has emerged from concern on the part of Congress, the GAO, and administrations of both parties that huge sums are being incorrectly paid to individuals who are not eligible for such payments.

In the vast majority of cases, the reason people are being taken off the rolls is not because there are deficiencies in the process, but because they are not disabled under the terms of the law. Many of them are on the rolls erroneously to begin with and many of them recovered after they came on the rolls, but were never previously reviewed.

We are now paying the price because the necessary emphasis was not put on quality in original decisions at certain points in the history of this program, and there was not a strong ongoing program for reviewing the existing rolls.

Once we complete our review of the existing rolls and, if we can maintain high quality in the initial determination and appeal process decisions, the proportion of terminated beneficiaries should fall off markedly.

There is no question that mistakes have been made and unfortunately, even if the decision accuracy rate improves, it is unreasonable to expect that we will reach perfection.

In a program as large as this, even a small percentage of errors translates into a substantial number of cases. We will continue to support the elements of the Ways and Means Committee bill outlined earlier, which are designed to resolve many of the problems and issues that have generated the concerns of members of this committee, and which have led to the hearing today.

The time has long since gone for demagoguery on this issue, and we are still getting a lot of it in some quarters. I think it's high time that we had some constructive, creative action on this issue.

We strongly urge that this committee support that kind of action within the framework of the House bill. It may well be good theater, it may well be good television and good headlines to blame this administration, as some have, for the problems, anomalies and mistakes that have made headlines in the course of this continuing disability investigation program.

That's a bum rap. Let's look at what has happened today in light of a thumbnail history of this program. The Congress enacted the disability program 26 years ago—a quarter century. It was an extremely strict program then, it is extremely strict now.

Over that quarter century the disability program has been in place, the Congress—both parties—successive administrations of both parties and any number of court decisions have acted to liberalize the eligibility criteria or contract or expand benefits as the temper of the times dictated.

If we have problems today, as Senator Levin pointed out, we have many at whom we can point the finger of blame. For a long time, for example, it was possible for a worker to get more in tax-free disability benefits than he or she could get on the job, which is a strong incentive to get on and stay on the program.

For a long time it was possible for convicted felons to collect disability benefits while sitting in prison for mass murders. Congress did finally act to stop that after 15 years.

For a long time most workers who made it into the program could rest assured that they were on a lifetime tax-free, adjusted-for-inflation retirement annuity. They would never be asked to prove continuing eligibility.

For a long time the disability insurance program offered a long-term tempting alternative to taking an early retirement at 62—rather than the regular retirement program—and accepting a 20-percent loss of benefits. And indeed, today more than half of all DI beneficiaries are over the age of 55.

For a long time the rules didn't change all that much despite startling advances in medical therapy and technology that made wholesale changes in our notions of what disability is.

There are people we see on the streets going to work every day who are suffering from handicaps and disabilities that are far more serious than those of many people who are now on the rolls.

I think that's important for people to understand because it's an important perspective, I think, for all of us to have. And for an unprecedented time in the mid-1970's, the Federal and State agencies responsible for administering this program had to grapple with the sudden creation of the supplemental security income program, which added millions of new disability cases to their workloads in a matter of months with precious little leadtime and obvious effects on the quality of decisions made on those who flooded into the program. Many of those decisions are now at issue in the CDI process.

All of these forces gathered over time to make the DI program perhaps the single fastest growing part of social security and perhaps the single most abused.

Between 1970 and 1980 the disability case load grew 75 percent and its costs by 500 percent. That was at a time when the national rates of long-term sickness and disabling injuries had not materially changed among the general population.

And the cost of living during that time went up by only 40 percent of the cost of this program. That is why the Carter administration and the Congress, and the Congress' own audit agency endorsed the Disability Amendments of 1980 for good reasons—obvious reasons. For the same reason this administration is pursuing the clear intent of Congress and the American taxpayer.

At the time when the Social Security system is fighting for survival in terms of both dollars and public confidence, we cannot tolerate any doubt about how we are spending $17 billion in trust-fund moneys this year, which is exactly the issue that we are talking about at this hearing today.

We can argue about whether it's possible within the 3 short years Congress has given us to right every wrong, to clean up every excess and to eliminate every abuse that has evolved in this program over the past quarter century.

But no, we cannot argue that there is no reason to act. We have no choice but to act. We are losing, as I mentioned earlier, $17,000 a minute out of all three trust funds combined—$24½ million a day out of funds that 36 million Americans depend upon to pay benefits every month.

Of that incredible deficit, we believe $7,600 a minute, or $11 million a day, is going to people who are ineligible for disability insurance under the law.

Mistakes are being made—it's regrettable. I will apologize for the mistakes, but I won't make excuses for them. If there are errors and failures in this program, they are not this administration's—they are the errors and failures of the U.S. Government over time.

That is precisely why we have supported those provisions of the Ways and Means Committee bill that will rectify those elements of the law and its administration that must be changed to insure that this program is fair.

Finally, that is precisely why Commissioner Svahn is moving as much as he can within the confines of the law to make the kind of long overdue improvements in the process of reviewing DI cases that I've outlined this morning.

With that I thank you very much, and I'll be glad to answer any questions.

Senator COHEN. Thank you, Mr. Simmons. I noted that your oral presentation—the conclusion of it—is considerably longer than the written one we have before us.

Mr. SIMMONS. I'm sorry.

Senator COHEN. I'd just like to comment on your statement about demagoguery.

First, let me assure you, and everybody here in this audience, that you won't find any demagogs sitting up here on this podium.

Senator Levin, Senator Pryor and others who are concerned about the issue certainly have gone to some lengths to make sure that we reduce this capacity that we have in the Senate and the House for theater.

What we really want is a discussion—an intelligent discussion—of the issues involved. And as I and Senator Levin and, of course, Senator Pryor would point out, we all have a measure of blame and responsibility in this matter.

I couldn't help but note that just this past week we engaged in a rather lengthy discussion of the budget in which amendments were offered to eliminate fraud, waste, and abuse from the budget.

Now everybody's for eliminating fraud, waste, and abuse, until it comes down to your own programs in which we seek to do so. So I can assure you that no one here is going to seek to exploit the very volatile issue dealing with people's disability payments for the purpose of any political gain.

But we are at least determined to correct our own errors, or those that we see as existing in the administration of a program authorized or mandated by Congress.

And it's in that context that we are holding these hearings today. It's within that context that we have asked you to come to testify about the kind of improvements you've made—not only the kind of errors that have been made, but the kind of improvements that have been made in the administration of the program.

We'll have witnesses coming from individual States to say, "This is our problem, this is why we are having so many difficulties out here."

We think there are some legitimate complaints, and I believe there are.

Mr. SIMMONS. I'd like to point out that many of the administrative improvements that we have made, or are planning, have been put together by a committee of State agency administrators that we have brought into Baltimore and consulted with very closely.

Senator COHEN. We're all in this together to meet an obligation to people who are truly disabled. We are also in this together to make sure that we can save money that's currently being wasted or abused by people who are not truly needy and dependent upon this program because they're not truly disabled according to the meaning of the law.

So I'd like to reassure you that there's no intent to either cast aspersions upon the Reagan administration or go back and point to the Carter administration or to point to Congress over the years that we've all been here because we've all made our share of mistakes.

But let us discuss now the questions about the notices that are sent to disability recipients. I think you indicated in your opening statement that many people who currently receive disability payments are under the impression or misapprehension that somehow it's a permanent payment that will never be reviewed and terminated. And I would tend to agree with you that that may be the perception of a lot of recipients.

But the problem that I have is that when you send a letter out, I'm not sure that people are really aware of what the consequences of a review may be.

For example, we tell them that their continuing disability is under "review," their claim is now "due for review." And the letter says the review is "to make sure that payments are made only to those who continue to meet all requirements." But we really don't spell out what that means, what are the requirements.

For example, I'm sure that most people are unaware that the past records they might have in their file are totally irrelevant. There is no presumption of validity of any records in the file older than 3 months. It's a totally de novo or new examination of their case.

Furthermore, I don't think they have much time. I think they have about 10 days once the due process notice is given, about 10 days in which to get a doctor and present evidence to prevent the censation decision from being made final.

Mr. SIMMONS. I think on that particular item I noticed that Mr. Ahart's prepared testimony refers to a GAO sample of 100 cases—which is probably not statistically valid, but I think an indication of what's going on out there—and that in not one of the 100 cases was the client not given sufficient time to develop a record.

The States have discretion to extend those days. The 10 days is a pro forma number; it says, contact us if you plan to submit evidence.

Very often the person will contact the office and negotiate an additional 30 days because for example, he lives out in California now.

Senator COHEN. I can't get a dental appointment, and I make it 6 months in advance. It's a problem getting doctors to conduct examinations, especially if it's not simply an update, if you've got to go back and get a thorough medical examination.

All I want to know is: at what point does the Social Security Administration make it clear that the claimant must provide detailed medical information—an entirely new record built—to establish his or her entitlement to continued disability payments?

Isn't that part of the problem we have right now?

Mr. SIMMONS. I'll ask Ms. Greenberg to address the details of that.

Senator COHEN. Ms. Greenberg, I guess what I'm saying is, why not spell out, say, your claim is under review, which means that past evidence will be disregarded? You must present your entitlement as if it were a brand new proceeding to demonstrate that you have the burden of proof of showing that you are entitled.

For example, I did a lot of workman's compensation work when I was practicing law. Once a disability determination was made, it was reviewed periodically. But the doctors only had to demonstrate that there had been no change in the condition for the individual to continue to receive benefits. Yet, the SSA ignores much of the claimant's past record, and imposes the burden on the claimant to prove his disability in so many days.

Ms. **Greenberg**. I think the point you make is a very interesting one and I'd like to give it further consideration.

I would like to distinguish between two letters which by your comments I'm not sure the audience would understand are, in fact, two letters. There is an initial letter that goes out to the individual saying, "we are going to review your case."

That letter contains a form for the person to fill out to tell us what he's been doing and his treatment sources. After that letter goes out, after the initial evidence is obtained, then if the State agency believes termination is appropriate, then a letter is sent out which says, "We propose to terminate your benefits. If you have additional evidence that you would like to submit, let us know in 10 days. And then, we'll give you more time if you need it."

So there are two letters.

Senator **Cohen**. But in both letters—in neither letter that I've looked at—does it really spell out the fact that you've got the burden of proof to go forward to show that you're entitled. And whatever your past disability was, is irrelevant.

Ms. **Greenberg**. I'd like to look at those letters again in light of your comment, but the thought that I hear you say is that in writing those letters we need to strike a balance so that people understand what's happening to them, but also so that we do not strike terror in their hearts.

I mean, we could write a terrifying letter, and I'm not sure that that would be a productive avenue to pursue either. So we've got to find a middle ground.

Senator **Cohen**. How about if you said, for example, "Congress has declared by law that all cases currently that are not permanent in nature must be periodically reviewed. This review means that you will now have the burden of establishing your entitlement for disability, and that you must bear the burden of proof to show that you are in fact disabled, and we require medical evidence to support your claim. Past evidence will be insufficient and not counted."

Wouldn't that be more direct and put everybody on notice? If you really want to blame somebody, blame us. It's Congress; we're the ones who've done this. We're concerned about waste and fraud. You could say that Congress made you do the reviews—the Devil made you do it or whatever—but these are what the rules are going to be.

These are the rules, and now you know it. You know about them.

Because I think the problem is that doctors are not familiar with what they must do to satisfy the reviewers. They may not even do a sufficient medical examination to establish the case.

I think a lot of the difficulties come about because people are not aware of what the ground rules are. Once those ground rules are firmly established, then I think we would have fewer errors which make the papers, make the headlines. We have terminations which clearly are not warranted, which is why you have so many reviews and reversals by the administrative law judges, I think, because the requirements weren't understood initially.

Ms. **Greenberg**. We will take another look at our letters to see whether we can accomplish that.

Senator COHEN. Let me talk about face-to-face interviews with claimants. Mr. Simmons, you indicated that under the new procedures—I'm not sure whether administratively or under the bill recommended by House Ways and Means—but you talked about the need to have face-to-face interviews.

I was interested in that because there has been quite a swing in the surveys estimating the number of ineligible recipients—anywhere from the 20-percent estimate by the GAO, that in 20 percent of the cases payments are being made that aren't truly deserved, to as high as 33 percent, I think, in some of the SSA's own evaluations.

Mr. SIMMONS. In the portion of the case review, the national sample that the statisticians tell us is 95 percent accurate, the payment error rate is around 27 percent, and the case error rate is around 30 percent. In other words, in 30 percent of the individual cases, the payments are out of whack.

Senator COHEN. But we go from 18 to 30 or even 33 percent. But I'm interested in what methodology is used.

Did you include face-to-face interviews?

Mr. SIMMONS. Let me ask Miss Bedwell to address that. This was a quality assurance audit done at the usual rate we do audits and reviews.

Ms. BEDWELL. We've done each study a little differently, but some studies included contact with the beneficiary. We did obtain additional medical evidence whenever it was needed to make a decision about the beneficiary's current disability status.

Senator COHEN. Haven't you found that it's a fact that the administrative law judges' reversals are right now about 66 percent? Senator Levin says it's as high as 66 percent of these cases that are being reversed. Haven't you found, when you have a face-to-face interview, that the chance of error is reduced substantially?

Mr. HAYS. Well, that argument can go both ways, Mr. Chairman. While the face-to-face process certainly can be viewed as an improvement, in the sense that it gives a complete picture of the terminated beneficiary—and I think that's an important thing to add to the reconsideration process, at least in these termination cases—it also does have an additional element of subjectivity, having the person before you, raising all the sympathies that we all feel, as compassionate human beings, for our fellow men.

Senator COHEN. Would you really have that if you had a computer simply punch in the key elements and say, "Here's our big computer down at SSA?"

Mr. HAYS. I hope that's not the alternative.

Senator COHEN. Well, let me stop right there because that's what's being done initially, isn't it? When you start to weed out those cases, don't you have, in fact, a computer that selects cases to send to the States for reviews?

According to a SSA March 1982 circular, "The cases initially selected for periodic review are those where the condition is most likely to improve without regard to when benefits began." That's what the circular says, "without regard to when the benefits began." But those cases selected are the ones where the condition is likely to improve—except that when you look at what is being done—we have a document describing the profile which, in fact, is used we find that age—younger recipients are selected—date of entitlement, and the amount of benefit are the key factors.

So, I assume these three factors are fed into a computer; then the computer is punched to go. And here's what you get in terms of those selected for reviews. Isn't that the way it works?

Mr. SIMMONS. Yes, it is, sir. The idea is to identify those cases first for the earliest review which are most likely to have those features. Now, this is an accepted practice in any income support program. I did it myself in New York when I was in the welfare department of New York. The only way you can do that is to go up to the record and say, "Well, here we have a person who is relatively young, whose disablility was relatively mild compared to some others on the list, and was obviously not permanent."

Senator COHEN. But, you don't look at the disability. The selection factors that I'm looking at are current age, date of entitlement, the benefit amount. It seems to me if you really want to get the cases, you should look at injury, the type of injury. Is that a factor you look into?

Mr. SIMMONS. As I understand it, the purpose of the intitial runthrough is to pull out the names of the people with those and other characteristics which, experience tells us, are the nonmedical characteristics of beneficiaries who are most likely to be no longer disabled. Then, the file is looked at to see what the disability is. A computer does not say that this person had a heart attack in 1942. All the computer says is this person is such-and-such an age and had earned such-and-such and is receiving such-and-such a benefit, all of which are indicators of recent attachment in the work force, for example, and mean a higher benefit. So, this person is more likely to be going back to work. After using those characteristics for the initial screening, you then do a review of the folders to determine the nature of the beneficiary's disability. You can pull a person like that out of the file, look at the folder, and it says, well, this person is old, or something like that. Then you just put that back, you don't run that one. That's known as a paper review.

Senator COHEN. So, in other words, you take the age, date of entitlement.

Mr Simmons. You have to have some factors to extract the names from the computer in the first place. It's just a process to get the characteristics which yield a sample of the cases which do yield extraordinarily high cessation rates. And that's proper to put those first, because those are the ones which are most likely to cease. That's why the cessation rate is running higher than the 18- or 27-percent rate. It's running at around 40 percent now. But that's because we are looking first at those cases most likely to be ceased.

Senator COHEN. What criteria are you using to determine that accuracy rate? I notice in the printed testimony you had 22, but you testified to 44 percent.

Mr. SIMMONS. That number, the 22, was a mistake by the person who drafted the testimony. That was based on the $2-billion-a-year figure that GAO had been using. Under the new study, it was $4 billion.

Senator COHEN. In any event, you consider age, which is a factor; younger claimants are chosen because you assume the chances for improvement are better, the date of entitlement and the amount of benefit. Then you get your preliminary list, right? Now, you look at the nature of the impairment, I assume, at that particular point?

Mr. SIMMONS. Yes, that's the first time that you would actually look at the nature of the impairment. And that's still the paper review, that's still being done.

Senator COHEN. Still on paper.

Now, let's go back to Mr. Hays' suggestion, that when you have those kind of face-to-face interviews, you have all that sympathy, that you really don't want to deal with at that level. Don't you think that that's the level to deal with all those issues, at the first level, rather than have a determination made and then go through the appeals process and say that on reconsideration now we can have the face-to-face and "Yes, Mr. Smith, we realize you've got a slipped disc in your back and the pain is, in fact, disabling. We can see the extent of that pain, and we've talked to your doctors."

It seems to me you would be better off and would eliminate the problems as far as the appeals process is concerned. We have so many appeals. The caseloads are increasing so dramatically—to have that face-to-face interview at the beginning, rather than half way up, would decrease the number.

Mr. SIMMONS. Given the capacity of our system, I would say that all of that review is done in Baltimore before it's being sent out to the States. So, at that stage, there's a practical consideration, that it couldn't be done at that stage. A lot of it would be wasted time, because a big——

Senator COHEN. I don't mean doing it in Baltimore. I mean, it goes up to the State and the State unit makes its initial determination.

Mr. SIMMONS. The cut we're talking about now is made in Baltimore by Social Security. And after that process, many cases are sent to the States. At that point, it still may be a waste of time, the claimant's time and the State's time, to do the initial review face-to-face. That's one reason why we have supported the element in the House bill that would extend that reconsideration period filing time to 180 days in order for a person to continue to receive benefits. But by the time it gets to the reconsideration process, then you have got the cases down to a manageable number, into a number of very close calls. A lot of these cases will be automatic. The State agency will say no, that person is still disabled and send it right back.

Senator COHEN. Let me go over the procedure. I'm not entirely clear.

Let's suppose you go through the computer, you punch all this out, and you get your preliminary list, you make a determination at that particular point. For example if its a spinal injury, he stays and is not reviewed.

Then, you have this other list. You say go to the States. You've got the local units; they're in the best position to handle this, they're closest to the people. They're the ones that could deal on a face-to-face basis with the people.

What I'm suggesting is why not, at that point, have a face-to-face determination made, particularly in cases where they're denied disablility insurance benefits? In other words, you've got one-third or two-thirds that are still disabled so they stay on. But this other one-third, "We have determined that you're not entitled."

Why not, in that case, at that stage, have the face-to-face evaluation, rather than deny the benefit, have it go up on appeal, saying "You're entitled to reconsideration," and at that point—which is your recommendation, I believe—have the face-to-face interview.

Mr. SIMMONS. The reconsideration level stays within the same agency.

Senator COHEN. I understand.

Mr. SIMMONS. The ALJ is beyond that. And what I think that would do would put an excessive burden on the agency because we would not need to do a face-to-face in 100 percent of the cases. Some of them would be so obvious.

Senator COHEN. Just when they deny—the initial instinct, looking at this paper, looking at this man's age, looking at the nature of the disability, looking at what we have for medical evidence—complete or incomplete, as it might be—"We have determined that you are not entitled to disability payments."

Why not, at that point, allow the claimaint in those cases to come forward and meet with that person?

Mr. SIMMONS. In effect, that's what you'd be doing, by saying, "You have a right to be reconsidered by the same agency within a reasonable time and your benefits will continue while that's going on, so come on in and we'll do it face to face." That will give them a chance to control the burden.

Senator COHEN. That's under your new policy?

Mr. SIMMONS. Under this new policy that's in the Ways and Means Committee bill. And the Ways and Means Committee has spent considerable time looking at this process, and their staff has come up with this as probably the best compromise between what you're talking about, doing everything up front, and doing something in the middle which prevents some of the workload at the ALJ end of the process.

So, we're helping by continuing benefits and by lengthening the possible time for appeal. Then that will smooth that process out. It will be a fairer shake, in that you will have the face-to-face early on. That is one of the anomalies of this program, and has been for 26 years, that the first time you actually see someone making a decision in your case, outside the very first day you walk in to apply, is when you get to an administrative law judge, which may be 6 months after the event happens.

Senator COHEN. I think that the change you recommended is a very positive improvement, especially payments during that period of challenge.

Mr. SIMMONS. As it is now, the payments would stop in 2 months.

Senator COHEN. Are you doing that administratively now?

Mr. SIMMONS. We can't pay the benefits more than the statutory 2 months now. That's why we need that bill. That bill will lengthen that period to 6 months, and allow benefits to be paid throughout that period. We think that's a major reform, an important reform. And it will go far toward evening out this process and not making it so incredibly difficult.

Senator COHEN. You mentioned the Bellmon report. I guess the question I have is how are you going to reconcile the standards?

As I understand it, the administrative law judges do take into account the factor of pain as being a contributing element in disability. Those at the State level do not take into account the element of pain. And what you're talking about is consolidating since it makes good sense to have one standard. You shouldn't have the adminstrative law judges saying, "Here's our standard, up here. And here's the State unit, down here." Two different elements are used in order to evaluate a person's disability.

It seems to me it only makes common sense to have one standard. The question is, which one is it going to be? Is it going to be the administrative law judges' or the State units'?

Mr. HAYS. Well, Mr. Chairman, it's interesting that you use the example of pain, because that is yet another example of something that is contained in the Ways and Means Committee bill, H.R. 6181. That bill does contain a specific statutory provision which would clarify for all decisionmakers, including the administrative law judges, the question of consideration of pain.

Senator COHEN. What does it say? How does it clarify that?

Mr. HAYS. Essentially it says that allegations of pain by themselves are not sufficient to constitute disability or an entitlement to disability. It requires, in addition, clinical findings that would support an allegation of the existence of pain.

Senator COHEN. Let me just tell you, in terms of back injuries, it's very difficult to show clinical evidence. Even orthopedic surgeons won't come in and testify. They can say, "We've done X-rays, and that doesn't show—we know the man is complaining of pain and it's radiating throughout his right leg. But we can't find, on the X-ray, evidence of spinal injury or dislocated vertebrae or anything else, or slipped discs. We've done a myelogram, and that's kind of mixed. The only way we can prove it is by going in and opening him up."

Do you see a problem in that?

Mr. HAYS. It's not a simple proposition. Clearly, it's one of the more difficult areas of the disability program.

But just because it's difficult doesn't mean that we shouldn't try to do something about it to straighten it out.

In terms of the overall problem of the discrepancies, the lack of uniformity in the standards, the situation is that in the past the administrative law judges have essentially been given the Social Security Act and the regulations with little additional supplementation or explanation or amplification they have been left essentially to do their own thing, trying to carry out the law and the regulations; whereas the State disability agencies and the other SSA components, at the lower level of the adjudication process, have had a much more detailed description of what the agency policy has been. This hasn't been an intentional wrongdoing by any means on the part of the administrative law judges; it's just a fact of life, that what has happened over the years has been essentially that two separate standards have developed, because the State agencies have had a much more detailed set of agency policy instructions to carry out.

We're in the process now of putting in one place a set of social security rulings which are binding on all levels of adjudication—State agencies and the administrative law judges, as well as our

Appeals Council. Through these binding Social Security rulings, we will have, I hope, by the end of this year, a single set of disability adjudicative criteria that all levels of adjudication will follow. And at least in theory, all levels will be marching to the same set of policies and criteria.

Senator COHEN. How do you account for the administrative law judges' reinstatements in 60, 65 percent of the cases? What are they doing wrong or right?

Mr. HAYS. First of all, I should point out, by way of preface, that the average reversal rate or allowance rate for all cases—not just CDI's but, for all cases coming before administrative law judges—is running at about 52 percent.

Currently, the reversal rate just on CDI cases is running about 60 percent.

Senator COHEN. As Mr. Simmons said, if you take a percentage like that, you're affecting a lot of people, large numbers.

Mr. HAYS. There are a number of reasons for that result with the administrative law judge. Most of them were explained in Mr. Simmons' opening statement. Some of the reasons are very legitimate. It's difficult to tell exactly what portion is perfectly legitimate.

The point is that, because of the way this process works it's possible that in a given case a State agency's decision to deny or terminate benefits may have been 100 percent correct at the time that decision was made, and the administrative law judge's decision to put the person on the roles, to reinstate them, may also have been 100 percent correct. A lot can happen in that period of time between the time of the initial State decision and the administrative law judge's decision.

Senator COHEN. Are you talking about new medical evidence being introduced?

Mr. HAYS. I'm talking about the fact that additional evidence is available to the administrative law judge in some cases. This is not a simple appellate review. This is what we refer to as a de novo process. The claimant, in effect, is almost going through a new application process with an administrative law judge and presents not only additional information that was not presented at the State level, but the claimant can also come in and allege an entirely different impairment. The administrative law judge can put that person on the roles on a totally different basis than what the claimant had originally applied under.

Mr. SIMMONS. I think it's important for the perspective here, too, to note that as the Pepper Committee noted in its report the other day, notwithstanding the numbers you hear about reversal rates or anything, the fact remains, at any given time on the disability rolls, three-quarters of the people on the rolls got there through State agency action, and only 25 percent are there or retained on the rolls because of the ALJ action—that is, the vast majority of decisions are made at the State agency level.

When we talk about reversal rates of two-thirds and all that, we're talking about a smaller number of people, obviously. Seventy-five percent of the time they're on the rolls because the State put them there.

Senator COHEN. Well, but they're on because they had a certain set of guidelines, and those guidelines are now being changed;

they're being changed now with the new review process. You're saying go back and do the whole case over again.

Mr. SIMMONS. Excuse me. Yes, that's an ongoing process. But I'm just trying to point out that the fact of the matter is that three-quarters of the people on those rolls are there because of State actions, because they allowed them on or keep them on. And ALJs' decisions that we're talking about here really are 25 percent or less.

Senator COHEN. Let me say, before I yield to Senator Levin, I think it's important that we have one set of standards, that we don't have one set for the State determination and another one for the administrative law judges. I think we've got to have one standard, that we should have as much consistency as possible.

I think we ought to agree on a determination of pain—that part of the criteria ought to spell it out, under what circumstances, and apply it at both levels.

I also agree with the proposal that you ought not—between the time you file, the initial decision is made, and the review process, there shouldn't be a changing or putting in of new medical facts. The decision ought to be based on the facts at the time the initial decision is made. If your condition deteriorates, file a new petition.

But the problem is, as far as I'm concerned, the length of time, the fact that payments are denied in the process.

Let's tell people what they have to do, establish reasonable timeframes, continue those payments, until you have a reasonably fair procedure in process, and I think you'll eliminate many of the problems. I don't think we ought to be shifting the evidence back and forth, overruling decisions at the lower level now that we have new evidence. That's not the way the judicial or quasi-judicial process ought to work.

So, I think I can support some of the provisions, provided you have the kind of notification up front, that we have the continuation of payments along the way, so you don't cut off somebody and then put the burden on them—long time delays—to somehow survive.

Mr. SIMMONS. I agree with that.

Senator COHEN. Senator Levin.

Senator LEVIN. Did you say you agree with that?

Mr. SIMMONS. With everything you say.

Senator LEVIN. Would you agree that, if there is no improvement in someone's medical condition, and that person has been on the disability rolls, that because of a change in standards, perhaps stricter standards, that that person should be removed from the rolls?

Mr. SIMMONS. That's a thorny issue that is now before the courts, as you know, and I'd prefer not to say something specifically to that.

I will say, in general, that our problem, the State's problem, the beneficiary's problem, is that we operate with what we have on the books now; and what we have on the books now says that, irrespective of when this person came on, here is the standard by which that person has to be judged. So we judge them.

There are cases where, as I've pointed out and as you have pointed out, there are people who have been on those rolls for years, who had no expectation of ever being reviewed, and who really expected that it was a lifetime retirement program.

I think it's a tragedy that our Government, over a quarter of a century, has let that happen. But it has let it happen. And now, in 3 years' time, we are expected to undo what has been done—in error, or in good faith, or bad judgment, and so forth.

And it is thorny. That's one of the reasons why we're so strong on the Pickle bill, as it's come forward. We hope we do get the relief. I think the people deserve it and the program deserves it.

Senator LEVIN. The Pickle bill is not going to solve that problem, is it?

Mr. SIMMONS. It's not going to solve that particular problem.

Senator LEVIN. Let's go back to that problem. And tell me whether you think it's fair to the people who are properly placed on the rolls, according to certain standards, and have been receiving disability benefits, that because of a change in those standards—in 3 years, 5 years, whatever—down the road, that they should be judged according to stricter standards and removed from the rolls?

Mr. SIMMONS. I think it's fair if the new standards are grounded in, for example, advances in medical technology. And I think it's fair if the person got on through a lapse in the administrative process, and shouldn't have been on in the first place. A lot got on in that way. I even had a hand in that, when I was a State administrator and SSI was coming along. And we looked at that and said, "Boy, here's something where we can get rid of a lot."

Senator LEVIN. I'm not referring to that. I'm referring to stricter standards as to what constitutes disability.

Mr. SIMMONS. I think the program has evolved over the years, in terms of medical technology, for example. Twenty years ago, a worker having a heart attack was considered to be permanently out of the work force; now it's routine to go back to work, and so forth.

I think if the person has improved, or if the condition is no longer considered to be that disabling, I think that is fair. But I'm trafficking there on what is going on in the court case, and I would rather not comment on that.

Senator LEVIN. Have they changed the definition of pain? To what extent would one consider pain?

Would you say that change in definition should be applied retroactively to someone who has been on the rolls?

Mr. SIMMONS. I would ask Ms. Greenberg to address that.

Ms. GREENBERG. I think, Senator, the question you are asking now, the one you just asked, get us to the point of some of the criticism that's been leveled at Social Security disability programs.

That criticism, particularly in the late 1970's, was that our guidelines were too general. As a result of general or vague guidance to State agencies, people were getting on the rolls who were not disabled, as we all intended "disabled" to be interpreted. Therefore, in the management of disability programs, we have issued clarifications. We have issued more specific guidelines in a lot of areas; and "pain" was one of them.

Having done that, those are the rules deciding disability as we administer the program today. And those are the rules we do apply in adjudicating disability.

**Senator LEVIN.** I understand that. But do you think it's fair that somebody who was properly on the roll, under a proper adjudication at the time, whether pain was to be considered, was properly applied, should now be removed from the rolls—although there's no improvement in that person's circumstances—because of a stricter definition of "pain?" That's my question.

**Ms. GREENBERG.** I don't think it's my place at this time to talk about fairness, as you might determine it or as I might determine it. It's a difficult question, and one that I think we need to air and talk about.

**Senator LEVIN.** You don't have an opinion on that question?

**Ms. GREENBERG.** I think my answer to your question is that it's a very difficult question.

**Senator LEVIN.** Is the Social Security Disability Trust Fund solvent?

**Mr. SIMMONS.** The fund itself is. It's the only one of the three funds that is in quite robust shape, in terms of income and outgo—but that's really immaterial. The tax rate that is dedicated to that was reallocated by the Congress in 1980, as you know, to help shore up the OASI fund.

Now the Congress has acted to merge all three funds, in effect for purposes of keeping the big one afloat until next fall. If the Congress does nothing to act, then all three of them go bankrupt next June whether or not the trust fund itself is adequately financed. When the tax rate was initially set, back, I believe, in the 1977 amendments, the projection was that far more people would be on disability in the future. Now, fewer are approaching the system, fewer than actually was expected. The trust fund itself will be quite healthy, but it's not really material to the problem.

**Senator LEVIN.** So, there are actually fewer people on the disability rolls than was projected at the time the rate was set?

**Mr. SIMMONS.** That's correct.

**Senator LEVIN.** You, then, did not mean to suggest, on page 4 of your statement, or at a later time, that the disability trust fund is running a deficit?

**Mr. SIMMONS.** No. It's the social security trust funds.

We've been discussing them in the aggregate because they are in the aggregate.

**Senator LEVIN.** It's the other trust funds, which were lumped together with the disability trust fund, which together make up the total deficit. Is that correct?

**Mr. SIMMONS.** That's correct. The disability trust fund is a very small part of the three trust funds.

**Senator LEVIN.** And that's very solvent?

**Mr. SIMMONS.** It's solvent.

**Senator LEVIN.** And, as far as you know, will continue to be so?

Now, I think that Congress clearly wants people off the rolls who are not disabled. I think that was clear. I hope it was clear before the Bellmon amendment. It was clear at the time of the Bellmon amendment.

The other side of that coin is that we want people on the rolls who are disabled. Would you agree that we want people on the rolls who are disabled?

Mr. SIMMONS. There is no question. This is an entitlement program, and the history of this program, and all parts of the social security program, has been on an outreach basis, to find people who are entitled.

Senator LEVIN. According to the memo that we have here, Mrs. Bedwell says, "We reverse decisions in 67 percent of appeals."

Is that a different figure from the 60 percent we heard this morning?

Mr. HAYS. Yes. That is a different figure.

The figure that you cite from Beverly Bedwell's memo refers to a group, a defined group, that does not represent all cases. They are being tracked through the process.

The figure that I cited, of close to 60 percent, is for all CDI cases, as opposed to this targeted group.

Senator LEVIN. Somewhere between 60 and 67 percent of the appeals were reversed by ALJ's; about half the terminations are appealed. Is that correct?

So, I think my figure is correct, in any event. By the end of 1983, under this program, there will be somewhere between 200,000 and 300,000 people removed from the rolls, who belong there, according to the ALJ's, at least. Is that correct?

Mr. SIMMONS. That is possible.

Mr. HAYS. Well, I would not accept the hypothesis that because the administrative law judges are reversing about 60 percent of the cases that they have reviewed so far that are CDI cases, that therefore 60 percent of all the people who have been taken off have been taken off improperly.

Senator LEVIN. I didn't say that 60 percent had been taken off improperly. I said: 60 to 67 percent of the appeals to the administrative law judges are reversed; and that 50 percent, approximately, of the people terminated appeal.

Mr. HAYS. Those two statements are correct.

Senator LEVIN. When you put those two statements together with the number of CDI cases, you come out with about a quarter of a million people who are going to be eliminated from the rolls, between the beginning of this program in 1981, and the end of 1983 who, according to the administrative law judges, should not have been removed from the rolls.

I'm just taking the math. You can see it when you multiply it.

Now, we've got to devise a system where we remove folks from the rolls who don't belong there, without eliminating a quarter of a million people from the rolls who do belong there. Until we have that system in place, I think that it's unconscionable to do what we're doing, which is to eliminate benefits before appeal.

Very simply, we should preserve those benefits as long as the appeal rate is somewhere between 60 to 67 percent, and have the folks appeal.

Mr. HAYS. I think that it also has to be noted, however, Senator, that our Appeals Council is finding that in approximately 20 percent of all the cases in which they have reviewed the administrative law judges' decisions, the administrative law judges' decisions were in error.

Senator LEVIN. I have no doubt that the Federal court review of your Appeals Council will provide an additional error rate. [Laughter.] And the court of appeals review of the district judges will add another 20 percent. And the Supreme Court, when they have decided these cases, you're going to have another reversal.

You're still talking about hundreds of thousands of people, in a few years, who ultimately will be restored to the rolls, after having been removed for somewhere between 9 months and a year. Is that a fair statement?

Mr. HAYS. Which I believe is the basis for Mr. Simmons's strong urging that we support those provisions of H.R. 6181 that would go so far to resolve those problems which you point out.

Senator LEVIN. Whether or not that bill resolves that problem is a different issue.

But would you agree that we now have a problem? We're in the midst of removing hundreds of thousands of folks from the rolls, who will be restored to those rolls.

Mr. HAYS. We certainly do have a problem, at least in my portion of that process, in that we have to make sure that the administrative law judge review process is as accurate as possible and provides the best quality adjudication. It's unfortunate that that portion of the process under my jurisdiction does have substantial defects; and we are trying to improve that process so that the decision of the administrative law judge, whether to grant benefits or to deny benefits, is the correct one.

Unfortunately, today that is not necessarily the case.

Senator LEVIN. Assuming your figure of 20 percent where your appeals council differs with the administrative law judges, that would reduce the number from a quarter of a million to 200,000, right?

Mr. HAYS. Your arithmetic method seems to be correct.

Senator LEVIN. You would say that instead of a quarter of a million people being removed from the rolls, who should not have been, we're only going to have 200,000 folks removed from the rolls, who should not have been?

Mr. HAYS. Again, I will reiterate my previous statements that there are many reasons for some of those cases being removed: additional evidence, worsening of conditions, et cetera.

Senator LEVIN. Let me read, now, the footnote from the GAO report which addresses a problem which you're now addressing. That's the difference of standards. And Senator Cohen has also addressed that:

> In a recently completed study of the Social Security Administration, over 3,600 decisions by the ALJ's highlighted clear differences in adjudicative criteria between ALJ's and the States as the major reason for the high number of decisions by the ALJ's to award benefits.
>
> For example, the ALJ's awarded benefits in 64 percent of the 3,600 cases, whereas the SSA's Office of Assessment, using State agency criteria, awarded benefits in only 13 percent.

That sounds all right?

Mr. HAYS. Yes.

Senator LEVIN. So we clearly have a problem of differing criteria being applied by ALJ's and by the States. And Senator Cohen and others have suggested—I happen to agree—that there's got to be a big difference, in terms of criteria as to, for instance, whether you abide by a court decision, and on minor points such as that.

I've got an interesting memo here, with a suggestion made that the State decisions not abide by court of appeals decisions, even though the State is in that court of appeals district.

Would you agree with that?

Mr. HAYS. Yes. That's absolutely correct.

Senator LEVIN. Your memo says that State examiners should not abide by the court of appeals decision, even for that region?

Mr. HAYS. That's correct.

Senator LEVIN. Has that been cleared with the Justice Department?

Mr. HAYS. Absolutely. This is the longstanding historic position of this Department. It has absolutely nothing to do with the current CDI process. That is the way that the Department has traditionally operated a national program, which has to follow a national policy, starting out with the Social Security Act.

And we have a policy of either acquiescing in court decisions and following them, or nonacquiescing in court decisions and not following them.

And this is a policy that is similar to that followed by some other Federal agencies. It has some similarities, for example, to the policy of the Internal Revenue Service. And this has been the longstanding position of this Department.

Senator LEVIN. Is that also true, even in instances where you have decided not to appeal the court of appeals decision?

Mr. HAYS. I believe that——

Mr. GONYA. If I might supplement Mr. Hays' comments, Senator, that is true. That is with the blessing of the Department of Justice.

And I would just want to supplement the comment by saying, don't be misled. Plaintiffs who participate in these actions—should those plaintiffs prevail, of course they are awarded benefits.

What we may be talking about here is the difference between the allocation of benefits and the principles that may be involved.

Also keep in mind, when we are at the court of appeals level, as well as the district court, we are talking about a substantial evidence test. And it is rare that you find there are two plaintiffs who present the same set of facts. So, while in principle, in the administration of a national program, we may find situations where we cannot follow a court of appeals decision, the plaintiff who is involved and who has brought that action is paid social security benefits.

Senator LEVIN. I don't doubt that the plaintiff is given the benefits.

The question is: If the court, in a certain area, says that under congressional intent, "pain" equals "A, B, and C," and must be considered in D, E, and F cases, you are saying that your examiners, even in the jurisdiction of that court, may ignore that ruling?

Mr. GONYA. What we find in the administration of the social security program are situations where, within one district, we have judges going different ways. The plaintiffs on one side of the street may be getting benefits because their case has been adjudicated by Judge Smith; on the other side of the street, they may have been denied because they have been reviewed by another district court judge.

Senator COHEN. What I think that he's suggesting is that you go to the level of the court of appeals.

Senator LEVIN. I'm talking about the court of appeals.

Mr. GONYA. Same problem.

Again, you would have in 11 different judicial districts, 11 different claimants who might be entitled, under 11 different standards. And you just cannot administer a program like the social security program in that perspective.

Senator LEVIN. And you're saying that Social Security—the Social Security Administration can, No. 1 ignore that decision in that region? And No. 2, that that's true, even though you decide not to appeal that case to the Supreme Court?

Mr. GONYA. We only do it, in many instances, after a ruling of nonacquiescence is issued. It is not done automatically. When a ruling of nonacquiescence is issued, that has to go to the Commissioner; and the decision is made at the Commissioner level.

Senator LEVIN. Is it true, what I'm saying, that you may decide, if there's a ruling of nonacquiescence, that you will not follow that decision, even in that circuit? And that could be true, even though you decide not to appeal the decision to the Supreme Court?

Mr. GONYA. That could be true.

Senator LEVIN. Now, finally, that's under the Bellmon amendment. The Bellmon amendment requires that there be a review by your Review Council of a number of decisions of ALJ's. Is that accurate?

Mr. HAYS. Yes.

Senator LEVIN. Do you pick those ALJ's at random for review?

Mr. HAYS. In part, we do.

Senator LEVIN. You don't pick the ALJ's who have the highest reversal rates?

Mr. HAYS. In part we do.

Senator LEVIN. What is the other part?

Mr. HAYS. We are currently reviewing approximately 15 percent of all administrative law judge decisions which grant benefits to claimants. That review has several components. First of all, roughly one-quarter of that review is composed of a random sample of all administrative law judges and all of their allowance decisions. We also have as part of the Bellmon review all new administrative law judges, those who have just been hired and have gone through the training class. We also take a group of cases which are referred to us by the Office of Disability Operations, which is the SSA component responsible for effectuating ALJ decisions, cases which their examiners think might be faulty. Finally, we do have, as part of the Bellmon review, a group of administrative law judges with the highest reversal rates.

Senator LEVIN. You say that you take a random sample of all ALJ's across the country?

Mr. HAYS. That is correct.

Senator LEVIN. There is testimony, which I'm not sure I can identify, which said the following:

> The Bellmon own-motion review started October 1 with 65 ALJ's selected for reviews. Those ALJ's who were selected had either the highest individual allowance rate or come from hearing offices with the highest overall allowance rates.

Is that true so far?

Mr. HAYS. That was true as of October 1 through the end of March. At that time we were reviewing approximately 7½ percent of all ALJ decisions. On April 1 and since then, we have doubled the size of the Bellmon review to approximately 15 percent. During the first 6 months of October through March it is correct that the only ALJ's being reviewed were those with the highest reversal rates or from the offices with the highest aggregate reversal rates. Since April 1 that is no longer true.

Senator COHEN. Could I just interrupt for a moment? Would you say the quality of the ALJ's is better or less than the State examiners? Are they highly qualified people? Are they more highly trained in this field of the law than, say, a State examiner?

Mr. HAYS. Well, yes and no. In the sense that administrative law judges are attorneys, by definition, one can certainly argue that they are more highly qualified. They obviously have a legal education and all of that. In the sense of experience and qualifications directly related to examining disability cases and making disability decisions, unfortunately, at least in past times, our administrative law judges received less training in adjudicating disability cases than State agency DDS personnel. Now we're trying to correct that. We're trying to beef up, expand, and improve our training we give to ALJ's.

Senator COHEN. What you're saying is that State examiners may be better factfinders than administrative law judges, who would be more skilled in interpreting the law.

Mr. HAYS. Well, what I'm saying is that the State disability examiners have received more training in the specific subject matter than our administrative law judges have.

Senator COHEN. Would it be fair to say that you feel that the administrative law judges are too liberal in their interpretation of what Congress really intended?

Mr. HAYS. No, I would not say that. I would not want to characterize administrative law judges as being either too liberal or too conservative. I'm not trying to put any sort of blame or characterize what has happened with the ALJ's in any way. The problem is not the administrative law judges. The problem has been with previous practice of really not paying too much attention to what standards the administrative law judges were following, not paying too much attention to providing the training and continuing training for administrative law judges.

Senator COHEN. What do these judges do? You say they don't have much training or skill in analyzing these cases or not as much as State examiners. What do they do? I mean, isn't that what they do for a living? Don't they make determinations?

Mr. HAYS. Absolutely. They are extremely hard-working, professional men and women who put out an enormous amount of work. What I'm saying is, that in the past the administration has not given sufficient attention to assuring that the Secretary's policy was both understood by the administrative law judges and followed by the administrative law judges.

Senator COHEN. What I was getting at is—let me just tell you my personal opinion. I think that administrative law judges have far more training than most State examiners. I can tell you in my own

State of Maine, they might get 8 weeks of training as compared to a much longer period for the ALJ's.

Mr. **Hays**. Excuse me, Mr. Chairman, but we have now expanded the training for new administrative law judges to be 6 weeks.

Senator **Cohen**. I'm talking about State examiners, not administrative law judges.

Mr. **Hays**. I understand, but I thought you said that the State examiners received only 8 weeks of training. My point is that administrative law judges now receive 6 weeks of training.

Senator **Cohen**. The problem is, though, administrative law judges are lawyers; right? They have a little bit more training than somebody who has a high school education—assuming they have a high school education. You give them 6 weeks or 8 weeks of training.

Mr. **Hays**. Obviously, there's no question that they have more.

Senator **Cohen**. What you were implying to me was, that administrative law judges may only have 6 weeks of training, whereas State examiners have more; therefore, there's more credibility to be given the State examiners.

Mr. **Hays**. I'm sorry. I did not use those words. I merely stated that in the specific subject matter of disability determination, I would not stipulate that an administrative law judge has more training or more experience in the disability area than a State agency DDS employee.

Senator **Cohen**. Would it be fair to say that an administrative law judge has more training and more capability in interpreting the law than does a State examiner whom you say has more capability in interpreting the Administrator's directives?

Mr. **Hays**. The problem, however, is that it is not the administrative law judge's responsibility to interpret the law. It is the administrative law judge's responsibility to apply the law.

Senator **Cohen**. Would you say he has more capability of applying the law than a State examiner?

Mr. **Hays**. I would certainly hope that any lawyer who has practiced for at least 7 years, as our ALJ's must in order to qualify as an ALJ, would have more experience in applying the law; yes.

Senator **Cohen**. Senator Levin?

Senator **Levin**. Is it typical at the moment to allow for 6 months additional benefits or review upon reconsideration, whichever comes first? Is that right? Mr. Simmons?

Mr. **Simmons**. Under H.R. 6181, I believe it's 6 months to apply. It expands from 60 days to 6 months.

Senator **Levin**. Now is this review clear what the 6 months' period leads to? It leads to a redetermination?

Mr. **Simmons**. It would be at the request of the beneficiary, face to face. This is another important——

Senator **Levin**. But the two-thirds or the 60 percent reversal rate of the ALJ's is following the reconsideration stage. Is that not correct?

Mr. **Simmons**. We believe——

Senator **Levin**. Is that not correct; first of all?

Mr. **Simmons**. Yes, sir.

Senator **Levin**. So there's a delay between the reconsideration and the ALJ decision which takes place and will continue to take place?

Mr. **Simmons**. There will always be some delay, just for scheduling purposes.

Senator **Levin**. And whatever the reversal rate is, after the Pickle bill is passed, if it were, would not extend the time payments during the period to reconsideration and the ALJ decision?

Mr. **Simmons**. That's correct.

Senator **Levin**. So if we're able to get the reversal rate down to 60 percent, say, to 40 percent, those 40 percent of folks, assuming that figure, would still lose their benefits between the time of reconsideration and the ALJ decision?

Mr. **Simmons**. That's correct.

Senator **Levin**. That's all I have.

Senator **Cohen**. Senator Pryor, you've been most patient.

Senator **Pryor**. This is a learning process for me. It's a very complex matter, and I applaud you, Mr. Chairman, and Senator Levin, for holding these hearings. It's most timely and something I think Congress must look at.

Mr. Chairman, I do have an opening statement I would like to be inserted in the record.

[The opening statement of Senator Pryor follows:]

### Opening Statement of Senator Pryor

Let me begin by commending Senators Cohen and Levin for scheduling this hearing to explore the growing problems with the Social Security disability payment terminations. Social Security Disability Insurance, for many individuals and families, is the final thread remaining between income maintenance and despair. Its existence is a reflection of this country's concern about adequate resources for persons unable to work due to physical or mental impairment. I am concerned that many individuals may be suffering tremendous hardships due to administrative insensitivity and misunderstandings.

It is appropriate that when a program reaches the spending level of the Social Security Disability Insurance program it should come under increased Congressional scrutiny. Such actions are necessary and reasonable. But when new administrative requirements are undertaken too hastily, such actions may become arbitrary and unreasonable. Information about the disability program is disturbing. For example, in one recent year, while the caseload for State agency staff increased over 200 percent, staff to perform the work increased only 29 percent. It is unrealistic to expect effective and efficient performance in such a situation. Moreover, the hardship falls unfairly on recipients because they often do not understand the impact of the new regulations or may not be able to obtain legal advice regarding their rights.

I welcome the opportunity today to explore these problems in more depth. Administrative Law Judges, Disability Insurance caseworkers, and Disability Insurance recipients deserve to know where they stand—and what is expected of them. The Social Security Administration has not fulfilled this need—it is up to Congress to do so now.

Senator **Pryor**. I also have an article from the Washington Post of May 3, "Who Screens Social Security Disability Rolls?". I think it would be appropriate to put it in the record.

Next, Mr. Chairman, I would like to read just a very short blurb from the Washington Post. I didn't bring my glasses—pardon me, it is the Wall Street Journal. You can see I don't have my glasses on. I'm disabled! [Laughter.]

The subheading here is "Getting the Bird". "Bureaucracy sleuth, James Boren"—by the way, that's kin folk of our Senator David Boren from Oklahoma—"will award his Order of the Bird to the

Social Security Administration who ruled a Vietnam veteran no longer eligible for disability benefits, despite a jaw wired shut, loss of a leg, two fingers, his spleen, and part of his stomach. 'The man can work and that's how our rules are,' according to an official." [1]

Now how can a case like this happen? I think this is one of the reasons that this hearing is so necessary. How can this occur?

Mr. SIMMONS. It can occur—if that is a mistake, I don't know the details of the case. I don't know whether all the facts of the case as you presented it are true or not. I would appreciate knowing the name of that person, but it can happen, because, as I testified earlier, and as I think we've tried to spell out here, there are a lot of anomalies in the system. The system is overloaded, and we are working to get the staffing up to it. We think we have now at the State agency level. There are many actors on the stage who have a finger in the process, including State and Federal officials, and many decisions are made in the program on the basis of a file and not on the basis of complete evidence. We have cases where someone with incredibly severe disabilities did not for whatever reason get medical evidence in or that evidence got lost. So that's why we have appeals in the program, to take care of cases like that—it's going to happen. In any situation where you have half a million cases, for example, you're going to have some mistakes. There are going to be mistakes, and we will do everything we can to rectify them.

We are supporting legislation in the House coming out of Ways and Means now, which will give us the wherewithal to have, for example, face-to-face reconsideration early on in the process, so people could actually see this person who's making the decision, and the person who makes the decision could actually see the person. You can bet that no examiner looking at a person like that is going to rule that he's not eligible.

Senator PRYOR. We've had quite a discussion on the decisionmaking structure at the ALJ level and discussed the ALJ system. I believe you stated that, in the hearing process you were going to add an additional 100 ALJ's.

Mr. SIMMONS. Plus we're increasing our staff by 25 percent.

Senator PRYOR. There have been some hints that the ALJ's may be somewhat liberal in their interpretation of applying the law to the facts. Would not one reason for this—I hate to call it "liberalism," but let's say "consciousness level"—be that it is the first face-to-face confrontation with a real human being that this recipient who is being challenged would have? Is this not correct? And then from this particular step, we go to the Appeals Council. I understand that that's 15 members?

Mr. HAYS. That's approximately correct.

Senator PRYOR. Again, I feel like I'm going back to nighttime civics class here, but who makes up the Appeals Council?

Mr. HAYS. The Appeals Council is a unit of the Office of Hearings and Appeals, which has been delegated the authority by the Secretary to make the final agency decision on all appeals coming through this appellate process that we've described.

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[1] Newspaper articles referred to appear on pp. 493 and 506.

Senator **Pryor**. Now at this point in the proceeding, is there a quota given to the Appeals Council as to how many cases or how many individuals, on a percentage basis, must be taken off of the disability roles?

Mr. **Hays**. Absolutely not.

Senator **Pryor**. There's no quota, no dollar figure even, indicated?

Mr. **Hays**. Their sole mission is to review the decision and determine whether or not that decision was correct, and I might add, Senator, that the Appeals Council, while they are reviewing approximately 15 percent of the ALJ decisions which have granted benefits to claimants, are also reviewing approximately 50 percent of all the ALJ decisions which have denied benefits to claimants. We're not talking solely about a process under which the Appeals Council reviews only cases in which the administrative law judge has awarded benefits. In fact, if the system is slanted or biased in any way, it is actually biased in the other direction.

Senator **Pryor**. Let's take Mr. Simmons, or maybe Ms. Greenberg, who has jurisdiction, I guess, for this entire program. Are you, either of you, under any form of quota, or dollar reduction or goals that may be adopted by Executive order?

Mr. **Simmons**. Absolutely not. And I'm glad that question came up, because it's one of those rumors or one of those charges to which it is so difficult to say, "Well, it's just not true," because you're arguing with somebody. Anyway, there is no quota system whatsoever. Any numbers that appear, any dollar figures that appear in the budget, for example, are estimates based on our experience up and down the road. They may be off by 10, 20, or 50 percent. We just don't know until we get there. When you plan a program like this, we didn't know if we were to pick certain cases, that a certain percentage of those would be expected to drop out. There's no quota set up anywhere in this program. I think it's being run under incredibly difficult circumstances as best we can, but it's certainly not being done with a quota on there.

Senator **Pryor**. Let's once again go back to the Appeals Council. Let's say we've had a determination by the ALJ now before the Appeals Council, and the recipient—let's say, Mrs. Jones—does not have the opportunity at the Appeals Council level to appear before the council. Is this correct?

Mr. **Hays**. She has the opportunity.

Senator **Pryor**. Through an attorney.

Mr. **Hays**. To make her case, so to speak. It's very unusual to have a personal appearance, and, in fact, Congress has moved in the direction of so-called closing the record at the point of the administrative law judge's decision, so the trend is to have no further development after the administrative law judge. Now what happens in many cases is the Appeals Council may send that case back to the administrative law judge, and the administrative law judge may gather further evidence or have Mrs. Jones come in for another hearing.

Senator **Pryor**. So the review is made solely on the record itself?

Mr. **Hays**. Essentially speaking, yes.

Senator PRYOR. I have had the staff make a diagram of this whole appeals process. By the way, a Federal judge has recently talked to me about this very complex and cumbersome process.

Let's say Mrs. Jones, who has been disabled for 5 years, all of a sudden goes out to her mailbox and opens the box and there is a notification that she is about to be cut off and the reconsideration process is going to begin.

At that moment how many people are involved in Mrs. Jones' case through this massive, complicated bureaucracy? It probably takes almost a year, or maybe even more in some cases, to reach final adjudication. How many people are involved in Mrs. Jones' case?

Mr. SIMMONS. Ms. Greenberg is trying to work that out.

Ms. GREENBERG. I will give you the decisionmakers.

Senator PRYOR. Decisionmakers. I am interested in caseworkers, file clerks, supporting personnel, and decisionmakers. Give me a couple of figures if you can.

Ms. GREENBERG. Let me start with the decisionmaker, and then we will come back to the ratio of support personnel, so it will get you where you want to go.

Senator COHEN. If I could, Senator Pryor, it is going to be a little difficult for Ms. Greenberg to do this. She has testified about the existence of a computer that is housed in Baltimore. There are computer programers, operators—I don't know how you would come up with a figure.

Senator PRYOR. Let me say this. I will take the chairman's admonition there, and if you would like to supply that for the record, I think it would be an interesting little fact because I think we are going to see many hundreds of people involved in Mrs. Jones' case.[1]

One final question. In the hypothetical case involving Mrs. Jones, does she have to go to the expense and the burden, not only of proof but also of financial responsibility, of demonstrating to the U.S. Government that, yes, I am disabled and cannot work? For example, she has a doctor's statement made in her behalf that states, "Mrs. Jones, without any question, is disabled." Maybe this doctor has been a family physician for years. He knows her, in this case very well.

Then let's say the Government hires a physician, and that physician, hired by the Government, paid for by the Government, renders an entirely different opinion relative to Mrs. Jones' capabilities to hold a job.

Who is believed? Which doctor is believed? Where is the burden? Is there a balance here? Does the presumption shift in favor of the family physician, who has known Mrs. Jones all these years, or the Government doctor who may have seen her only for a 10- or 15-minute period?

Mr. SIMMONS. That is one of the many areas where obviously judgment comes into play, and very often it is possible that she would have a family physician who is not competent in some disability or some condition. But we do have consulting physicians who work for us full time at the regional level and in Baltimore to work on areas where there is a legitimate reason for dispute.

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[1] See p. 229.

That is why we have the ALJ system. That is why we have reconsideration. A person can go out and get a third doctor's opinion to rebut the second doctor's opinion, for example. And that is related to a real judgment call.

There has to be, under the law and under the regulations some objective medical evidence that something is wrong.

Senator PRYOR. One final question in this area. These doctors now, are they full-time physicians paid for by the Government, by the Social Security Administration, or do they perform this function on a part-time basis and have a private practice?

Ms. GREENBERG. There are doctors and there are doctors. I am sorry, I can't give you a quick answer. The State agency employs doctors, usually on a part-time basis, who are still practicing in their community. Within social security and in our review process, we do the same, and we also have full-time physicians on our staff.

Senator PRYOR. I see. I think at this point, Mr. Chairman, that is all the questions I have.

Senator COHEN. Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman. Just a few additional questions. Mr. Hays, you are saying that you are not saying that the ALJ's are too lenient; you are not saying they are too strict. Yet you singled out 65 ALJ's for review because they either had the highest individual allowance rates or they came from hearing offices with the highest overall allowance rate.

What could anybody read into that selectivity other than the fact that you were going after the most lenient ALJ's?

Mr. HAYS. I imagine you have read the report that was submitted to the Congress the so-called Bellmon study. The study that was done of 3,600 cases found, among other things, that the decisions by administrative law judges who had higher than average or higher than normal reversal rates were more error prone than either those ALJ's with about average reversal rates or with lower than average reversal rates.

So, in order to start somewhere, we began in that way to target the high reversing ALJ's because of the studies and reports that indicated that those ALJ's had a higher probability of error in their decisions.

Senator LEVIN. Are you saying to this committee that when you decided to review, your Appeals Council decided to review on its own motion decisions involving human beings which could be reversed, starting October 1, that you decided to pick the most lenient ALJ's for review and only those between October 1 and April 1, only those coming from the hearing offices with the highest overall allowances, and you did that because you had to start somewhere, that it was done randomly?

Mr. HAYS. I am saying that we began by targeting the ALJ's with the highest reversal rates because of studies that indicated that their decisions had a higher probability of error than any other group of administrative law judges.

Senator LEVIN. They were not selected randomly? It was because of studies that the most lenient judges were the most error prone?

Mr. HAYS. I cannot accept the use of the word lenient. The word that I have used is those with the highest reversal rate. I refuse to characterize that as either being too lenient or too liberal.

The fact is the ones with the higher reversal rates have a higher probability of error.

Senator LEVIN. Have you compared those judges to the judges who reversed fewer cases in terms of your report on the Bellmon amendment?

Mr. HAYS. In fact, we are doing a study right now of those ALJ's with a lower than average reversal rate.

Senator LEVIN. You have reported to the Congress on that?

Mr. HAYS. Yes. Part of that report did, in fact, find that the lower reversing ALJ's, as well as the average reversing ALJ's, did not have that same higher probability of error.

Senator LEVIN. OK. So, in order to make your report, you had to compare higher reversal rate ALJ's with lower ones immediately?

Mr. HAYS. Yes.

Senator LEVIN. You focused for 9 months just on the higher ones and later on decided to focus on the lower ones?

Mr. HAYS. I am sorry. Perhaps——

Senator LEVIN. Would you just explain this to us then? I am going to try it again. It is your memo. It says,

> The Bellmon own-motion review started on October 1 on 65 ALJ's selected for review. Those ALJ's who were selected had either the highest individual allowance rates or come from hearing offices with the highest overall allowance rate.

Mr. HAYS. There was a study that started, and was completed, prior to October 1. That study was of 3,600 cases, and one of the many findings of that study was that ALJ's with a higher than average reversal rate had a higher probability of error.

Therefore, we began the ongoing review process, as opposed to that study, which was prior to that, on October 1, by reviewing the decisions from the ALJ's with the highest error rates.

Senator LEVIN. And that ongoing review process continues?

Mr. HAYS. It continues, but in an expanded form, under which we now, in addition to the targeted portion, also reviewed a random sample of all ALJ's, as well as other components which I described in my answer to your previous question.

Mr. SIMMONS. We have, in effect, doubled the size of the sample.

Senator LEVIN. It should have been done that way in the first place so the wrong signal should not get out. When you select on your own motion and review just ALJ's, you know, this is not just a study we are talking about; we are reversing human beings' cases.

Mr. HAYS. But at that same time, Senator, to keep it in perspective, at the same time we were reviewing 7½ percent of decisions to grant benefits, we were at that very same time reviewing well over 50 percent of the decisions to deny benefits to claimants.

Senator LEVIN. But I am talking about your own-motion review. I think you know what I am talking about.

Mr. HAYS. That process is the same process as the review of denial decisions.

Senator LEVIN. Two short questions. Hopefully, the new adjudicative criteria will be subject to notice and comment. Mr. Simmons, Mr. Hays, you mentioned you were seeking new adjudicative criteria which would apply to everybody at all levels. Is that going to be subject to notice and comment?

Mr. HAYS. The new consolidation, if you will, of a single set of adjudicative standards will be published in the form of social security rulings. Those social security rulings are not published as regulations and do not have a public comment period.

Senator LEVIN. The answer is no, right?

Mr. HAYS. The standards will not be subject to public comment.

Senator LEVIN. I would hope that this committee would look very carefully at that. It seems to me it is a critical issue.

Summing it up, at least for my part, Mr. Chairman, it seems to me that what we are doing in these 2½ years is pushing over a million people through a system which we know is inadequate. I think it is simply outrageous to do that. We know that in the years 1981, 1982, and 1983 that there will be about 1,600,000 people who will be reviewed for disability.

We know so far that about 50 percent of those are going to appeal their termination and that 60 to 65 percent of those appeals will succeed, and we know that for a period of 9 months to a year those literally hundreds of thousands of people are going to be without benefits, although they are entitled to benefits.

Now, I think we should do something about it now. The Pickle bill doesn't succeed in doing it because it stops at the redetermination stage, reconsideration stage. It doesn't solve the problem of that period between reconsideration and the administrative law judge decision, which can be 9 months to a year.

And, we should do something about it, and we should have the help of the Social Security Administration in doing something about it because just as none of us want folks on the rolls who don't belong there, we want folks on the rolls who do belong there, with the same passion, I hope at least the same passion and maybe more.

If we have to err, I think we would want to err on the side of someone being on the roll who belongs there rather than someone not being on it who doesn't, but at least with equal passion. And I don't feel that passion coming from the Social Security Administration.

And, I think it is in your interest. We have the same interest. We want people on the rolls who belong there. We don't want them there if they don't belong there.

Now, we need a proposal. We need something to happen before we push another million people through, and that is what we are talking about, coming up in the next year and a half, another million people being pushed through a system which we know has a huge reversal rate. We know it, and we can do something about it with your help.

I think we ought to have your help and can, and I solicit your help, and I think we all do. We want your help. It is not a partisan issue. It is not Carter, it is not Reagan, it is not the Congress, it is not the executive. It is all of us. We are all part of this right now. We are all part of it.

We know there are hundreds of thousands of folks out there who are going to be eliminated from those rolls, who are going to be reinstated on appeal to the ALJ's. We know it. It is coming for sure, and we have a chance to do something about it. Let's work together and do something about it. That is my plea.

I am not pointing blame or trying to make political hay or taking partisan advantage. It would be to me despicable for anybody to take political or partisan advantage on that misery.

Mr. SIMMONS. I think we have indicated here that we are aware there are serious problems with this thing. We are aware that all of us are part of the solution. We are ready to work with the Congress to come up with that solution, but we have got to get something moving. It is going to take legislation no matter which way the Congress decides to go. It is going to take some congressional action to do it.

If you want us to expand the CDI process, lengthen it out, or otherwise change it, it has got to be done through legislation. The bureaucratic machinery that is built around this program can be vastly simplified and streamlined by some good legislation, such as the Pickle bill, but we have got to have something.

Senator LEVIN. Do you have a recommendation for that legislation?

Mr. SIMMONS. We have. It has been made within my testimony. I indicated what we are doing, and I listed right at the end the elements of the House bill that we strongly support that is coming up in Ways and Means now.

Senator LEVIN. Thank you, Mr. Chairman.

Senator COHEN. Let me just indicate, as we close this particular panel's testimony, I want to associate myself with Senator Levin's remarks throughout this hearing. He has never once indicated to me that he sought to exploit an issue because of political advantage.

I tried to indicate in my opening remarks that we are a part of the problem as well. We are the ones who legislate, and sometimes I think we fail to take into account the kind of impact that our recommendation, our amendments on the floor have upon people when we call for the elimination of fraud, waste, and abuse.

It is easy to get up on the Senate floor and say, let's eliminate $10 billion, because we know there is $10 billion of waste in the Government. So we eliminate $10 billion and we don't take into account that that means real people out there are going to get hurt. So, we have a large measure of responsibility as well.

Neither Senator Levin nor any other member of this committee has ever conveyed to me the desire to exploit this issue. I think what I come away with from this particular hearing, and I think it has been a good one, is that—I think I can paraphrase one of my colleagues from Arizona—moderation in the pursuit of congressional mandates can be a virtue. [Laughter.]

Particularly when we are dealing with people who are the least able among us, we ought not to take a congressional mandate to do something and run into that with a passion which ignores the real serious problems that these individuals face. That is one thing. Moderation can be a virtue in this particular case.

Second, Ms. Greenberg, let me emphasize this again, I think it is better—I don't like the choice about terrifying people as opposed to misleading them—but I think it is better to terrify people rather than mislead them. I think it is better to inform people rather than to sooth their anxieties until the point when they are suddenly denied benefits.

So, I would hope you would change the notice—and I think it can come administratively and not through legislation—and tell people. Tell them exactly what we are doing. Blame it on the Congress, saying Congress wants us to review your case. Review means start from scratch. Go get your doctor; bring a full, complete medical file in because we are going to make a determination from this point on as to whether you are entitled.

I think any other way of notification—you are under review, you have to show your continued disability—that implies that the SSA is you are going to accept the status quo as a starting point, and that is not true. So it is better to inform people or terrify people rather to than mislead them.

The third point: I think we have to have more uniformity. We simply cannot have two standards, one for administrative law judges and another for State agencies. We have got to have the same standard. We need a more expedited review process, and we need relief pending the appeals process, and I think those are the things that I come away with from this hearing.

Mr. Simmons, I know we have kept you and your associates a long time, but if you could have someone stay?

Mr. SIMMONS. We would appreciate the opportunity, sir. We will leave people here.

Senator COHEN. I don't intend to have you respond to individual cases, but I just want someone who is aware of the kind of issues that will be raised so that we can at least see whether we can correct them, but not individual cases. With that, I thank the panel.

[The prepared statement of Mr. Simmons, with attachment, follows:]

## Prepared Statement of Paul B. Simmons

Mr. Chairman and Members of the Subcommittee

I appreciate the opportunity to appear before your Subcommittee today to discuss the Social Security Administration's process for conducting periodic reviews of disability eligibility. I am accompanied this morning by Ms. Beverly A. Bedwell, Associate Commissioner of the Office of Assessment, Mr. Donald A. Gonya, Assistant General Counsel, HHS, Social Security Division, Ms. Rhoda Greenberg, Director of the Office of Disability Programs, and Mr. Louis B. Hays, Associate Commissioner of the Office of Hearings and Appeals.

### Introduction

From the inception of the disability benefit program in 1956, the definition of disability has always been very strict, and can only be met by the very severely disabled. Partial disability, which is recognized in many other benefit programs, is not sufficient for Social Security disability benefits.

The Social Security Act provides that a claimant's impairment(s) must be so severe that he is not only unable to do his previous work but cannot, taking into consideration his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. So long as this work exists in the national economy, it does not matter whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. The disability must be expected to result in death or must have lasted, or be expected to last, for a continuous period of 12 months or more. This is the statutory language, not SSA's interpretation of the statute. The same definition of disability applies not only to those initially filing for

BENEFITS, BUT ALSO IN DETERMINING WHETHER BENEFICIARIES SHOULD REMAIN ON THE ROLLS.

THE ORIGINAL DEFINITION OF DISABILITY FOR SOCIAL SECURITY BENEFITS WAS EVEN MORE SEVERE THAN THE PRESENT ONE; IT REQUIRED THAT THE IMPAIRMENT BE EXPECTED TO RESULT IN DEATH OR TO BE OF LONG-CONTINUED AND INDEFINITE DURATION. THE PRESENT DEFINITION WAS ADOPTED IN 1955, AT WHICH TIME THE CONGRESS INDICATED THAT IT EXPECTED SSA TO REVIEW THE CONDITION OF BENEFICIARIES PERIODICALLY TO ASSURE PROMPT TERMINATION OF BENEFITS WHEN A BENEFICIARY CEASED TO BE DISABLED.

HOWEVER, ASIDE FROM STATUTORY CHANGES IN THE DEFINITION, ADVANCES IN MEDICAL SCIENCE HAVE RESULTED IN DE FACTO CHANGES. DUE TO THE AVAILABILITY OF KIDNEY TRANSPLANTS, BYPASS SURGERY, AND NEW MEDICATIONS FOR MENTAL ILLNESSES, FOR EXAMPLE, CERTAIN MEDICAL CONDITIONS WHICH WERE PERMANENTLY DISABLING IN THE PAST MAY NOT BE DISABLING TODAY. THUS, MEDICAL ADVANCES MAY REQUIRE CHANGES IN CDI PROCEDURES SINCE PEOPLE CONSIDERED PERMANENTLY DISABLED WHEN THEY CAME ON THE ROLLS MAY NO LONGER BE DISABLED. IN ADDITION TO LIBERALIZING THE DEFINITION, CONGRESS MADE OTHER ELIGIBILITY REQUIREMENTS FOR DISABILITY LESS RESTRICTIVE; FOR EXAMPLE, THE INSURED STATUS REQUIREMENTS WERE LIBERALIZED TWICE.

A NUMBER OF OCCURRENCES IN THE 1970'S RAISED CONCERNS ABOUT THE PROGRAM. WHILE THE PROGRAM GREW RELATIVELY SLOWLY DURING THE 1960'S, IT BEGAN TO GROW RAPIDLY DURING THE EARLY 1970'S. IN FY 1969, SSA RECEIVED 700,000 CLAIMS FOR DISABILITY BENEFITS. BY 1974, THE NUMBER OF DISABILITY CLAIMS PER YEAR HAD GROWN TO 1.2 MILLION. PART OF THIS GROWTH CAN BE ATTRIBUTED TO ADVERSE ECONOMIC PERIODS BECAUSE HIGH UNEMPLOYMENT ENCOURAGES SOME WORKERS WITH SIGNIFICANT HEALTH PROBLEMS TO FILE FOR DISABILITY BENEFITS.

IN ADDITION, OVER 500,000 CLAIMS UNDER THE BLACK LUNG PROGRAM, WHICH STARTED IN 1970, HAD BEEN FILED OVER A RELATIVELY

SHORT PERIOD OF TIME, AND SSI DISABILITY CLAIMS ADDED ALMOST ANOTHER MILLION CLAIMS A YEAR AFTER THAT PROGRAM'S IMPLEMENTATION IN JANUARY 1974. THE ADVENT OF THESE NEW PROGRAMS REQUIRING DISABILITY DECISIONS PUT A STRAIN ON THE DISABILITY DETERMINATION PROCESS. THE RESULT WAS TREMENDOUS PRESSURE TO PROCESS CLAIMS QUICKLY AND REDUCE THE BACKLOGS. AT THE SAME TIME, THERE WAS AN EFFORT TO HOLD DOWN PROCESSING COSTS, PRODUCING A CONFLICT BETWEEN QUALITY AND QUANTITY.

BY 1975 THESE FACTORS RESULTED IN THE HIGHEST DISABILITY INCIDENCE RATE IN THE HISTORY OF THE DISABILITY INSURANCE PROGRAM; THERE WERE 7.1 DISABLED WORKER BENEFICIARIES PER THOUSAND WORKERS. WHILE DISABILITY INCIDENCE HAS FLUCTUATED WIDELY OVER THE YEARS, THE RATES OF SICKNESS AND INJURY HAVE NOT CHANGED APPRECIABLY.

CURRENTLY, THE SOCIAL SECURITY TRUST FUNDS ARE RUNNING A DEFICIT THAT MOUNTS BY $17,000 PER MINUTE, AND 44 PERCENT OF THAT TOTAL CAN BE ATTRIBUTED TO THE PAYMENT OF DI BENEFITS TO PEOPLE WHO ARE NOT DISABLED.

AS INCIDENCE RATES AND COSTS INCREASED, CONCERNS BEGAN TO BE EXPRESSED ABOUT THE QUALITY OF ADMINISTRATION OF THE DISABILITY PROGRAM. IN 1979, BOTH THE CARTER ADMINISTRATION AND THE CONGRESS MADE RECOMMENDATIONS FOR IMPROVING THE ADMINISTRATION OF THE PROGRAM AND CUTTING COSTS, CULMINATING IN THE ENACTMENT OF P.L. 96-265, THE "SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980." THESE AMENDMENTS CONTAINED PROVISIONS AIMED AT (1) RESTRAINING THE COSTS OF THE PROGRAM (E.G., A CAP ON FAMILY BENEFITS AND RESTRICTIONS ON DROPOUT YEARS); (2) IMPROVING WORK INCENTIVES; AND (3) IMPROVING PROGRAM ADMINISTRATION (E.G., CLOSING THE RECORD AFTER THE HEARING, OWN-MOTION REVIEW OF ALJ DECISIONS, AND PREEFFECTUATION REVIEW OF INITIAL DECISIONS). AMONG THE LATTER WAS THE PROVISION FOR PERIODIC REVIEW OF THE SOCIAL SECURITY DISABILITY ROLLS.

## HISTORY OF THE CDI PROCESS

SSA HAS ALWAYS REVIEWED DISABILITY CASES TO ASSURE THAT BENEFICIARIES' DISABILITIES ARE CONTINUING. HOWEVER, BEFORE THE PERIODIC REVIEW PROCESS WAS ENACTED IN 1980, ONLY CERTAIN KINDS OF DISABILITY CASES WERE REVIEWED: (1) THOSE IN WHICH THE DISABLED BENEFICIARY'S MEDICAL CONDITION WAS EXPECTED TO IMPROVE; (2) THOSE IN WHICH THE BENEFICIARY'S EARNINGS RECORD INDICATED WORK ACTIVITY; AND (3) THOSE IN WHICH A BENEFICIARY VOLUNTARILY REPORTED WORK ACTIVITY OR MEDICAL IMPROVEMENT.

IN RECENT YEARS, SSA BEGAN TO QUESTION WHETHER THIS CDI PROCESS WAS ADEQUATE. IT WAS CLEARLY NOT DESIGNED TO IDENTIFY CASES IN WHICH THE INITIAL DETERMINATION OF DISABILITY WAS INCORRECT, OR THOSE IN WHICH, BECAUSE OF THE STATUTORY CHANGES AND MEDICAL ADVANCES I MENTIONED EARLIER, THE IMPAIRMENT MIGHT NO LONGER BE CONSIDERED DISABLING. ALSO, ONLY A SMALL PERCENTAGE OF THOSE CASES IN WHICH IMPROVEMENT COULD BE EXPECTED WERE BEING REVIEWED.

CONGRESS WAS ALSO CONCERNED ABOUT THE EFFECTIVENESS OF THE CDI PROCESS, AND, AS I MENTIONED IN 1980 THEY ENACTED THE PERIODIC REVIEW REQUIREMENTS. THIS PROVISION REQUIRES SSA TO REVIEW ALL NONPERMANENT DISABILITIES AT LEAST ONCE EVERY 3 YEARS AND PERMANENT DISABILITIES AT SUCH TIMES AS THE SECRETARY CONSIDERS APPROPRIATE. THE LEGISLATION REQUIRED THAT SSA BEGIN THE PERIODIC REVIEW IN JANUARY 1982.

AS IT TURNS OUT, THE CONCERNS WHICH LED TO ENACTMENT OF P.L. 96-265 WERE WELL FOUNDED. IN FACT, THE SITUATION WAS EVEN WORSE THAN WE HAD IMAGINED.

A 1981 GAO REPORT, ENTITLED "MORE DILIGENT FOLLOWUP NEEDED TO WEED OUT INELIGIBLE SSA DISABILITY BENEFICIARIES," INDICATED THAT AS MANY AS 584,000 BENEFICIARIES, ABOUT 18 PERCENT OF THE DISABILITY ROLLS, DID NOT MEET THE ELIGIBILITY CRITERIA. THE REPORT POINTED OUT THAT THE COST TO THE SOCIAL SECURITY TRUST

FUNDS OF INCORRECT PAYMENTS TO PEOPLE NOT DISABLED COULD BE AS MUCH AS SOME $2 BILLION PER YEAR.

OTHER DATA ARE EVEN MORE ALARMING:

-- A SPECIAL SSA REVIEW OF 24,000 CASES (REPRESENTATIVE OF 60 PERCENT OF THE DISABILITY BENEFICIARY POPULATION) INDICATED THAT 33 PERCENT WERE NOT DISABLED.

-- ANOTHER SPECIAL SSA REVIEW OF A STATISTICALLY VALID RANDOM SAMPLE OF 2,800 CASES (REPRESENTATIVE OF THE ENTIRE DISABILITY ROLLS) INDICATED THAT 30 PERCENT WERE NOT ENTITLED TO BENEFITS.

-- BASED ON THIS 2,800 CASE STUDY, SSA WAS ABLE TO DETERMINE THAT AS MUCH AS $4 BILLION IS PAID OUT ANNUALLY TO PEOPLE WHO ARE NOT DISABLED.

## ACCELERATION OF PERIODIC REVIEW

IN LIGHT OF FINDINGS IN GAO AND SSA STUDIES THAT HUGE SUMS OF BENEFITS WERE BEING PAID INCORRECTLY, THE ADMINISTRATION DECIDED NOT TO WAIT UNTIL 1982 TO ACCELERATE THE PERIODIC REVIEW PROCESS MANDATED BY THE CONGRESS. THE DECISION TO GO TO ACCELERATED REVIEW WAS ALSO PRUDENT ADMINISTRATIVELY. IF WE HAD WAITED UNTIL JANUARY 1, 1982, WE WOULD HAVE HAD TO PROCESS 800,000 CDI'S IN A 9-MONTH PERIOD. INSTEAD, BY STARTING IN MARCH 1981, WE HAD 18 MONTHS IN WHICH TO SPREAD THIS WORKLOAD.

THE ADMINISTRATION'S DECISION TO ACCELERATE THE REVIEW OF THE DISABILITY ROLLS WAS FULLY SUPPORTED WITH APPROPRIATE STAFFING AND OTHER NECESSARY RESOURCES. IN FISCAL YEARS 1981 AND 1982, WE SIGNIFICANTLY INCREASED STAFFING AND FUNDING FOR THE STATE AGENCIES WHICH MAKE DISABILITY DETERMINATIONS FOR SSA IN INITIAL AND RECONSIDERATION CASES, INCLUDING CDI'S. TOTAL STATE AGENCY STAFF INCREASED 33 PERCENT BETWEEN FY 1980 AND FY 1982, WHILE FUNDING INCREASED 64 PERCENT FOR THE SAME PERIOD.

STAFF OF THE OFFICE OF HEARINGS AND APPEALS, WHICH HAS RESPONSIBILITY FOR ADJUDICATING HEARINGS, ALSO INCREASED 12 PERCENT AND FUNDING LEVELS FOR OHA ROSE 36 PERCENT BETWEEN FY 1980 AND FY 1982.

I THINK IT IS IMPORTANT TO NOTE AT THIS POINT THAT, THIS YEAR, WE ESTIMATE SPENDING OVER ONE-HALF OF OUR ADMINISTRATIVE BUDGET TO RUN THE SOCIAL SECURITY AND SSI DISABILITY PROGRAMS, WHICH ACCOUNT FOR ONLY 17 PERCENT OF THE COMPARABLE BENEFIT POPULATION.

## OVERVIEW OF THE CDI PROCESS

BEFORE I DISCUSS THE IMPACT OF THE CURRENT CDI PROCESS, I WANT TO GIVE YOU AN OVERVIEW OF HOW THE PROCESS WORKS. AS THE FIRST STEP, SSA CHOOSES THE CASES FOR REVIEW BASED UPON PROFILES, DEVELOPED THROUGH SPECIAL STUDIES, OF THE CHARACTERISTICS OF CASES INVOLVING NONPERMANENT DISABILITIES IN WHICH BENEFICIARIES ARE MOST LIKELY TO BE INELIGIBLE.

SSA THEN TRANSFERS THE CASE FOLDERS TO THE STATE AGENCIES, WHICH NOTIFY BENEFICIARIES THAT A REVIEW HAS BEEN UNDERTAKEN. THE BENEFICIARY IS ASKED TO GIVE THE STATE AGENCY INFORMATION ABOUT THE CURRENT STATUS OF HIS CONDITION AND ABOUT WHEN AND WHERE HE HAS RECENTLY RECEIVED MEDICAL TREATMENT. THIS INFORMATION IS USED TO OBTAIN ALL CURRENT MEDICAL EVIDENCE THAT IS AVAILABLE.

IF THE CURRENT MEDICAL EVIDENCE IS NOT DETAILED ENOUGH, OR IF THE BENEFICIARY HAS HAD NO RECENT MEDICAL TREATMENT, THE STATE AGENCY ARRANGES A SPECIAL EXAMINATION OF THE PERSON'S PRESENT CONDITION, CALLED A CONSULTATIVE EXAMINATION, AT GOVERNMENT EXPENSE.

THROUGH THE FIRST 13 MONTHS OF THE ACCELERATED REVIEW, ABOUT 54 PERCENT OF THE CONTINUING DISABILITY CASES REVIEWED BY

THE STATE AGENCIES HAD CONSULTATIVE EXAMINATIONS PERFORMED. THIS IS ALMOST 15 PERCENT HIGHER THAN THE PERCENTAGE OF INITIAL AND CONTINUING CASES IN WHICH CONSULTATIVE EXAMINATIONS WERE PERFORMED. I SHOULD NOTE THAT, IN FISCAL YEARS 1983 AND 1984, WE ARE BUDGETING FOR A 60-PERCENT CONSULTATIVE EXAMINATION RATE IN CONTINUING DISABILITY CASES. I MIGHT MENTION THAT WE HAVE TAKEN SEVERAL SIGNIFICANT STEPS TO IMPROVE OUR MONITORING OF STATE AGENCY PURCHASES OF MEDICAL EVIDENCE. I AM SUBMITTING THE ATTACHED DESCRIPTION OF THOSE STEPS FOR THE RECORD.

I WANT TO EMPHASIZE THAT IN EVERY CDI CASE WE OBTAIN EVIDENCE OF THE BENEFICIARY'S CURRENT MEDICAL CONDITION--EITHER FROM HIS PHYSICIAN OR THROUGH A CONSULTATIVE MEDICAL EXAMINATION--BEFORE MAKING A DECISION.

THE STATE AGENCY THEN EVALUATES THE MEDICAL EVIDENCE AND DETERMINES WHETHER THE BENEFICIARY CONTINUES TO BE DISABLED WITHIN THE MEANING OF THE LAW.

THOSE INDIVIDUALS WHO ARE FOUND TO BE STILL DISABLED ARE INFORMED BY LETTER THAT THEIR ELIGIBILITY HAS BEEN REVIEWED AND THEIR BENEFITS WILL CONTINUE. THOSE WHO ARE FOUND TO BE NO LONGER DISABLED ARE GIVEN ADVANCE NOTICE OF THIS FINDING AND ARE GIVEN 10 DAYS IN WHICH TO ADVISE THE STATE AGENCY THAT THEY DISAGREE WITH IT AND PLAN TO SUBMIT ADDITIONAL EVIDENCE. THE BENEFICIARY HAS 10 MORE DAYS TO PRESENT THE ADDITIONAL EVIDENCE.

IF, AFTER EVALUATING THE ADDITIONAL EVIDENCE, THE STATE AGENCY STILL FINDS THAT THE BENEFICIARY DOES NOT MEET THE DEFINITION OF DISABILITY IN THE LAW, THE BENEFICIARY IS NOTIFIED OF THIS FINDING AND IS INFORMED THAT HE MAY APPEAL THE DECISION BY REQUESTING A RECONSIDERATION WITHIN 60 DAYS OF THE NOTICE OF TERMINATION. I MIGHT NOTE THAT UNDER THE LAW THE BENEFICIARY IS PAID BENEFITS FOR THE MONTH THAT THE DISABILITY IS TERMINATED AND FOR 2 ADDITIONAL MONTHS.

When a reconsideration is requested, the State agency secures updated medical evidence from the beneficiary's treating sources and requests a consultative examination if one is needed. The reconsideration determination is made by different State agency personnel than made the initial decision. The beneficiary is then notified of the reconsideration decision and his appeal rights. The beneficiary has 60 days after notification of the reconsideration determination to request a hearing before an Administrative Law Judge, at which point he may appear in person to present evidence and give testimony. If dissatisfied with the ALJ's decision, the beneficiary may appeal the ALJ's decision to SSA's Appeals Council, and ultimately to a Federal court.

## IMPACT OF CONTINUING DISABILITY REVIEWS

Next I want to discuss the CDI process in terms of: (1) the impact on claimants and beneficiaries, (2) the quality of the review process; and (3) the impact on hearings.

## IMPACT ON CLAIMANTS AND BENEFICIARIES

Since March 1981 when we began the accelerated review, over 345,000 disability beneficiaries have had their eligibility reviewed, and more than 139,000 have had their benefits terminated. The process has affected new claimants for disability benefits too; overall State agency processing times rose from 44.6 days in the first quarter of 1981 to 50.3 days in the first quarter of 1982. I must emphasize though that while processing times have increased, the accuracy rate for initial State agency decisions has improved slightly. Also, some of the increase in processing times is due to factors such as the preparation of personalized denial notices as required under the 1980 amendments and the requirement for a physician's signature on medical evidence.

We believe that some of the adverse reaction to the CDI process stems from public misunderstanding of the fact that the periodic review process is mandated by law, and that the definition of disability for Social Security benefits is very strict. The adverse reaction of some disability beneficiaries to periodic review is also based on misunderstanding. Most beneficiaries never expected to have their cases reviewed again; in their own minds they have "retired" on disability. As a result, terminated beneficiaries have to make tremendous psychological adjustments. And of course current economic conditions--unemployment is high and jobs are scarce--add to their anxieties.

## QUALITY OF THE REVIEW PROCESS

To monitor the performance of State agencies in making continuing disability decisions, SSA performs a quality assurance (QA) review. The review involves a random sample of recent State agency DDS decisions and is designed to determine the extent to which State agency decisions properly reflect the eligibility criteria in the law and regulations. Under this review, 97.5 percent of continuing disability determinations in the 6-month period ending March 1982 were found to be correct; the figures were 97.4 percent for continuances and 97.6 percent for terminations. This shows that the accuracy of our CDI reviews is very good. Of course there is always room for improvement and, as I will discuss later, we are undertaking a number of initiatives aimed at making improvements.

## IMPACT ON HEARINGS

Our hearings workload has been increasing and as a result processing times have increased. Total hearings requests have increased from 136,000 in the first 6 months of FY 1981 to 152,000 in the same period in FY 1982. In March 1982, we

RECEIVED 31,000 REQUESTS, WHICH IS BY FAR THE MOST WE HAVE EVER RECEIVED IN A SINGLE MONTH. THERE HAS ALSO BEEN A SLIGHT INCREASE IN PROCESSING TIME FOR HEARINGS, FROM 164 DAYS IN FY 1981 TO 173 DAYS AS OF APRIL 1982.

FOR BUDGET PURPOSES, WE ARE PROJECTING 328,000 REQUESTS FOR HEARINGS IN FY 1982 AND MORE THAN 400,000 IN FY 1983, COMPARED TO 281,000 IN FY 1981. THIS PROJECTED INCREASE IN HEARINGS REQUESTS INCLUDES EXPECTED INCREASES DUE TO CDI HEARINGS REQUESTS. HOWEVER, APPEALS ARE EXPECTED TO LEVEL OFF TO SOME EXTENT ONCE WE HAVE REVIEWED THE EXISTING DISABILITY ROLLS.

LOWER LEVEL DECISIONS ARE NOW BEING REVERSED BY ALJ'S IN APPROXIMATELY 60 PERCENT OF CDI CASES. THIS OF COURSE RAISES THE QUESTION, "IF OUR QUALITY APPRAISAL SHOWS A 97.5 ACCURACY RATE FOR INITIAL STATE AGENCY CDI DECISIONS, WHY IS THE ALLOWANCE RATE AT THE HEARINGS LEVEL SO HIGH?"

THERE ARE A NUMBER OF FACTORS WHICH CAN RESULT IN ALLOWANCES AT THE HEARINGS LEVEL, INCLUDING THE SUBJECTIVITY OF THE DECISIONMAKING PROCESS, THE FACE-TO-FACE CONTACT WITH THE BENEFICIARY THAT FIRST OCCURS AT THE HEARING LEVEL, THE POSSIBILITY OF PROGRESSIVE WORSENING OF THE CLAIMANT'S MEDICAL CONDITION DURING THE COURSE OF THE VARIOUS REVIEWS OF THE CLAIM, AND THE FACT THAT ADDITIONAL EVIDENCE MAY BECOME AVAILABLE AT THE HEARING LEVEL FOR THE FIRST TIME. HOWEVER, TO A LARGE EXTENT THE HIGH ALLOWANCE RATE IS DUE TO INCORRECT DECISIONS BY ALJ'S. UNDER OUR PROGRAM OF OWN-MOTION REVIEW, AS REQUIRED BY THE BELLMON AMENDMENT, THE APPEALS COUNCIL IS NOW REVIEWING 15 PERCENT OF ALJ ALLOWANCE DECISIONS. THIS REVIEW INCLUDES BOTH INITIAL CLAIMS AND CDI CASES. WE ARE FINDING DEFECTS IN 50 PERCENT OF THE DECISIONS WE REVIEW. IN APPROXIMATELY ONE OUT OF EVERY FIVE CASES REVIEWED, THESE ERRORS ARE SO SUBSTANTIAL THAT THE APPEALS COUNCIL MUST EITHER REVERSE THE ALJ'S DECISION OR REMAND THE CASE BACK TO THE ALJ FOR FURTHER ACTION.

## SSA'S INITIATIVES TO IMPROVE THE CDI PROCESS

NOW I WOULD LIKE TO TELL YOU ABOUT SOME OF THE ACTIONS WE ARE TAKING TO IMPROVE THE CDI PROCESS. THESE IMPROVEMENTS FALL IN THREE GENERAL CATEGORIES: (1) THOSE INTENDED TO IMPROVE THE OVERALL CDI PROCESS; (2) THOSE AFFECTING QUALITY CONTROL; AND (3) THOSE WHICH WILL IMPROVE THE APPELLATE PROCESS.

FIRST, WE ARE TRYING TO UPGRADE THE OVERALL CDI PROCESS AS FOLLOWS:

- WE ARE REFINING OUR SELECTION CRITERIA SO THAT MORE BENEFICIARIES WHO ARE PERMANENTLY DISABLED ARE IDENTIFIED AND EXEMPTED FROM THE 3-YEAR PERIODIC REVIEW PROCESS. IN MARCH, WE IDENTIFIED SEVERAL NEW CATEGORIES OF IMPAIRMENTS WHICH SHOULD BE CONSIDERED PERMANENT AND, AS ADDITIONAL EXPERIENCE IS GAINED, WE EXPECT TO ADD ADDITIONAL IMPAIRMENTS TO THE LIST. THIS WILL CUT DOWN ON THE NUMBER OF REVIEWS AND WILL PERMIT A MORE PRODUCTIVE USE OF STATE AGENCY RESOURCES AND REDUCE COSTS.

- OUR REGIONAL OFFICES ARE WORKING WITH THE STATE AGENCIES TO SET UP MORE EFFECTIVE INTERNAL REVIEWS OF ERROR-PRONE CASES.

- WE ARE TESTING THE USE OF MULTIPLE CONSULTATIVE MEDICAL EXAMINATIONS IN CERTAIN CASES, PARTICULARLY THOSE INVOLVING PSYCHIATRIC IMPAIRMENTS.

- STARTING IN MARCH, WE BEGAN REQUIRING THE STATES TO FURNISH MORE DETAILED EXPLANATIONS OF TERMINATION DECISIONS.

-- We are attempting to improve decisionmaking by physicians employed by SSA and State agencies through training, particularly training regarding the evaluation of psychiatric impairments and an individual's remaining capacity to work.

Second, we are trying to improve quality control through the following efforts:

-- As part of our quality control process we review a sample of CDI cases after a decision has been reached as to whether the disability is continuing or has ceased. To improve this procedure we are taking two steps: (1) in termination cases, we are conducting the quality review before benefits are stopped, and (2) we are doubling the number of quality reviews of termination cases--from 13,500 cases annually to 27,000.

-- In our quality review process, we will study terminations to ascertain what kinds are especially error-prone, and subject these kinds of cases to a more intensive review before a final decision is made. This should enable us to prevent more of these errors in the future.

-- We are also studying the feasibility of doing initial development of CDI cases before they are released to State agencies for investigation in order to eliminate additional permanent disability cases from the 3-year review.

The third area where we are making improvements is in the CDI appellate process:

-- In general, we are determining that a disability has terminated as of the date the beneficiary is notified of the termination.

-- We are giving priority to appeal requests in termination cases.

-- We are hiring more than 100 additional ALJ's this year, increasing the size of the corps to 800. We are also increasing the ratio of support staff to the ALJ's from the past level of approximately four to one to a ratio of five to one.

-- Through improved training, upgraded equipment, and new workflow and organizational arrangements, we are increasing the productivity of hearing offices.

## PENDING LEGISLATION

Next, I would like to talk about H.R. 6181, which was approved by the House Ways and Means Committee on May 19. On April 28, Secretary Schweiker announced the Administration's support for protections designed to build a 3-year transition period while the review of the existing disability rolls is being completed. The Administration supports the provision in H.R. 6181 permitting beneficiaries to continue to receive benefits until a reconsideration determination is reached. We also support legislation allowing face-to-face contact in termination cases during the reconsideration process.

We are continuing to work with the Congress on the technical aspects of this legislation, but we believe that, overall, the bill takes a constructive approach which is in line with our desire to improve the program so that disabled people who genuinely need help can get it.

I WANT TO SUMMARIZE THE IMPROVEMENTS THAT H.R. 6181 WOULD MAKE IN THREE MAJOR AREAS: (1) BENEFIT PROTECTION FOR TERMINATED DISABILITY BENEFICIARIES; (2) AN IMPROVED RECONSIDERATION PROCESS; AND (3) UNIFORM STANDARDS FOR DECISIONMAKING IN ALL DISABILITY CASES.

THE BILL IS INTENDED TO PROTECT TERMINATED BENEFICIARIES BY PERMITTING THEM TO ELECT TO HAVE BENEFITS CONTINUE UNTIL A RECONSIDERATION DETERMINATION IS MADE BUT WITH A 6-MONTH LIMIT ON THESE PAYMENTS. (IF THE DENIAL IS CONFIRMED UPON RECONSIDERATION, THESE BENEFITS WOULD HAVE TO BE REPAID.) THE BILL WOULD ALSO PROVIDE 4 ADDITIONAL MONTHS OF "ADJUSTMENT BENEFITS" FOR TERMINATED BENEFICIARIES WHO HAD BEEN ON THE ROLLS FOR AT LEAST 36 MONTHS. ALSO, IN GENERAL, THE BILL WOULD NOT COUNT AS OVERPAYMENTS BENEFITS PAID FOR ANY MONTHS PRIOR TO RECEIPT OF NOTICE OF TERMINATION DUE TO MEDICAL RECOVERY. WE HAVE ALREADY INSTITUTED THIS POLICY ON AN ADMINISTRATIVE BASIS. THE LATTER TWO PROVISIONS WOULD BE TEMPORARY; THEY ARE JUST INTENDED TO PROVIDE ASSISTANCE TO LONG-TERM BENEFICIARIES WHO ARE TERMINATED DURING OUR CURRENT REVIEW OF THE EXISTING DISABILITY ROLLS.

SECONDLY, THE BILL IS INTENDED TO STRENGTHEN THE RECONSIDERATION PROCESS FOR TERMINATED DISABILITY BENEFICIARIES BY OFFERING A FACE-TO-FACE EVIDENTIARY HEARING AND BY AFFORDING INDIVIDUALS 6 MONTHS, INSTEAD OF THE CURRENT 60 DAYS, IN WHICH TO REQUEST A RECONSIDERATION.

FINALLY, THE BILL IS DESIGNED TO ENHANCE THE UNIFORMITY OF DISABILITY DECISIONS BY: (1) REQUIRING THAT THE SAME CRITERIA BE USED TO MAKE DISABILITY DETERMINATIONS AT ALL ADJUDICATIVE LEVELS; (2) INCLUDING IN THE LAW AN EXPLICIT STATEMENT AS TO HOW ALLEGATIONS OF PAIN ARE TO BE EVALUATED IN THE DISABILITY ADJUDICATION PROCESS; AND (3) REQUIRING THE REVIEW OF 15 PERCENT OF ALJ ALLOWANCES IN FY 1982 AND 25 PERCENT EACH YEAR IN FY'S 1983-87. THE ADMINISTRATION STRONGLY BELIEVES THAT UNIFORMITY MUST BE IMPROVED, AND I HAVE TOUCHED ON SOME OF OUR INITIATIVES IN THIS AREA.

## CONCLUSION

IN CONCLUSION, MR. CHAIRMAN, I WOULD LIKE TO REITERATE THE FACT THAT THE PERIODIC REVIEW PROCESS IS PART AND PARCEL OF OUR ONGOING MISSION TO ENSURE THAT DISABILITY BENEFITS ARE PAID ONLY TO THOSE INDIVIDUALS WHO MEET THE CRITERIA ESTABLISHED IN THE LAW. THE PERIODIC REVIEW PROCESS HAS EMERGED FROM CONCERN, ON THE PARTS OF THE CONGRESS, GAO, AND ADMINISTRATIONS OF BOTH PARTIES, THAT HUGE SUMS ARE BEING INCORRECTLY PAID TO INDIVIDUALS WHO ARE NOT ELIGIBLE FOR SUCH PAYMENTS.

IN THE VAST MAJORITY OF CASES, THE REASON PEOPLE ARE BEING TAKEN OFF THE ROLLS IS NOT BECAUSE OF DEFICIENCIES IN THE PROCESS, BUT BECAUSE THEY ARE NOT DISABLED UNDER THE TERMS OF THE LAW--MANY OF THEM WERE ON THE ROLLS ERRONEOUSLY TO BEGIN WITH AND MANY OF THEM RECOVERED AFTER THEY CAME ON THE ROLLS. WE ARE NOW PAYING THE PRICE BECAUSE THE NECESSARY EMPHASIS WAS NOT PUT ON QUALITY IN ORIGINAL DECISIONS AND THERE WAS NOT A STRONG ONGOING PROGRAM FOR REVIEWING THE EXISTING DISABILITY ROLLS. ONCE WE COMPLETE OUR REVIEW OF THE EXISTING DISABILITY ROLLS AND WE MAINTAIN HIGH QUALITY IN THE INITIAL DETERMINATION AND APPEAL PROCESS, THE PROPORTION OF TERMINATED BENEFICIARIES SHOULD DECLINE.

THERE IS NO QUESTION THAT SOME MISTAKES HAVE BEEN MADE AND, UNFORTUNATELY, EVEN IF OUR ACCURACY RATE IMPROVES, IT IS UNREASONABLE TO EXPECT THAT WE WILL REACH PERFECTION. IN A PROGRAM AS LARGE AS THE DISABILITY PROGRAM EVEN A SMALL PERCENTAGE OF ERROR TRANSLATES INTO A SUBSTANTIAL NUMBER OF CASES. WE WILL CONTINUE TO DO OUR BEST TO IMPROVE OUR ACCURACY RATE.

I WILL NOW BE GLAD TO ANSWER ANY QUESTIONS WHICH YOU OR THE SUBCOMMITTEE MEMBERS MIGHT HAVE.

## SSA Actions Taken to Improve Management of Consultative Examinations

Listed below are brief summaries of a wide range of actions taken to improve consultative examinations (CE's). These actions have been directed toward providing clear program direction on CE report requirements and maintenance of a quality process as well as establishing a more formal program of monitoring State agencies in this area.

- Basic SSA policy was issued in Social Security Ruling 82-14, which covered CE physician qualifications, independence of CE physicians from other program or claimant relationships, content of CE reports, and physician signatures on CE reports.

- Detailed instructions have been issued to State agencies in the SSA Program Operations Manual in order to achieve improved CE reports nationally. These instructions cover a broad range of aspects of the CE process including:

  - Selection of CE sources

  - Arrangements for a CE, including provision of pertinent materials in file

  - Report content and signature requirements

  - Guidelines for review of CE reports

  - Specific medical specialty report requirements

- The initial monitoring by SSA of State agency CE management processes has been completed. All States initially provided general descriptions of their practices for oversight of CE's as well as specific data on the "top ten" providers. These responses were analyzed and weaknesses in handling complaints, keeping records, maintaining ongoing oversight and other areas were identified. Regional Commissioners then worked with each State to improve oversight. Followup reports have now been submitted from all regions.

- The second stage of SSA monitoring efforts is now underway. An in-depth protocol has been developed for reviewing all aspects of a CE provider's operation and the State agency's oversight of it. Joint SSA-State onsite reviews of 30 CE providers are taking place this month and next.

- The next stage in our monitoring program will be the issuance of administrative guidelines to State agencies. These will specify what States must do in their oversight of CE providers. In addition, specific instructions will be issued to Regional Commissioners regarding the need to monitor State agency compliance with the administrative guidelines. These materials will be issued by July 1, 1982.

- All State agency administrators will be attending the first disability programs management forum next week. The forum will include a series of workships designed to allow administrators to share problems and solutions for managing the CE process.

- Additional technical policy guidelines will be issued in the next several weeks. Such issues as whether CE providers are bound by the Privacy Act and how CE providers should respond to requests for interrogatories by claimant's attorneys have been raised as we have explored the complaints of the legal community concerning CE providers.

- We are developing a methodology for review and comparison of CE providers through the case review process. At present, review procedures do not provide for the sampling of cases by CE provider nor are we certain what can be learned from case reviews targeted by CE provider. Studies will be geared to determine whether there are significant differences between CE's done by volume providers and those done by other sources. This should begin later this year.

Senator **Cohen**. Our next witness will be Ethel Kage, who is from Reed City, Mich. Mrs. Kage, I know it has been a very difficult year for you. We appreciate your coming to testify.

Mrs. Kage, I understand you don't have a written statement, but you're going to proceed and just give us an oral presentation of the rather difficult experience you have had.

## TESTIMONY OF ETHEL A. KAGE, REED CITY, MICH.

Mrs. **Kage**. Yes.

First, I want to thank you, Mr. Chairman and Senators, for giving me this opportunity to come and share the personal experiences that we've had with the Social Security Administration and perhaps help in some small way to alleviate the situations which arose that caused us so much pain and suffering.

I'll start just briefly with my husband's history. He'd been on social security disability since 1974. Prior to that time, he'd been on insulin for a diabetic condition since he was 12 years old. For the past 15 years, prior to his death, he was taking four shots a day to effectively control that diabetes.

In the mid-1960s, the blood vessels in his left eye hemorrhaged, leaving him blind in his left eye. Shortly after that time, we became aware of a process, photocoagulation which fuses the blood vessels, and he had this performed on his right eye three times, until all the blood vessels were fused. Even after this process, it was a very touch and go situation because any sudden jolt would have severely damaged the eye. So, it was strictly a preventive measure, but not completely foolproof.

As I said, in 1974, he went on social security disability. This came about due to a stroke he had in May 1974. He had come home from work. He was working approximately 70 miles from home at that time. He worked for the Michigan Department of Transportation on a survey crew. Friends had stopped over. When they left, he went out to bring our car around to hook up the trailer to go camping, and that's when it happened. He began honking the horn. I went out, and he was paralyzed on his right side, he could not see at all to speak of, and was confused, and his speech was slurred.

He entered the hospital for tests and observation. Of course, the diagnosis was he had had a stroke. By the next day, movement was restored in his right side. However, his vision was still impaired, to the point that he felt completely boxed in. Two days later that did—that feeling did leave him, but he still had tunnel vision. And that condition remained until he died.

Senator **Cohen**. Was he still partially paralyzed?

Mrs. **Kage**. Pardon?

Senator **Cohen**. Was he paralyzed?

Mrs. **Kage**. No. The paralysis left the following day.

We applied for and received social security disability without any problems whatsoever. In fact, it went through very speedily.

It's interesting, I think, to note that the same doctors who supported our disability claim at that time—the reports were accepted and taken into consideration on which, apparently, the disability was provided—when the reconsideration hearing came up, those same doctors were completely ignored, and apparently their reports were not taken into consideration at all.

In fact, Dr. Vining, who was the internist and diabetic specialist, who had been our doctor for some 17 to 20 years, states in his letter, which was written after Dick died:

> I believe that the disability determination service standards for disability are erroneous, false, and misleading.
>
> When a physician who has been entirely in charge of a patient's medical care states that a patient is totally disabled, it seems totally unrealistic and completely ridiculous for any physician seeing him one time on a brief examination to countermand a statement of disability on the part of an experienced physician on the basis of a single visual field determination. On Mr. Kage's residual vision, he was claimed to be no longer disabled and was directed to return to work by the Disability Determination Service.

I note with interest Senator Pryor's question on this very thing, whether the family physician's reports were considered or whether it was strictly for the Government doctor. In our case, it was strictly the Government doctor.

Senator COHEN. What did you do when you first got the notice? What process did you go through?

Mrs. KAGE. When we first received the notice of disability—it's called a Notice of Disability Examination Form. It merely states the disability determination service has been asked to review our file, with the idea of elimination. At that time, they notified us that he had an appointment with an ophthalmologist in Mt. Pleasant, 45 to 50 miles from our home, and that the appointment—we had to confirm it, and it was up to us to get to that appointment. Otherwise, it would be considered that we were not interested in doing anything to refute this at all.

We did go. The doctor—Dick was probably with the doctor 15 to 20 minutes at the very most. And as his doctor said in his letter, it was merely an eye-field vision exam.

The ophthalmologist in Grand Rapids, the doctor who had performed the photocoagulation, had written in his letter, copies of which had been sent to the Disability Determination Service—the bottom line that he wrote in his letter is that "This gentlemen is in no condition for employment."

These two doctors, as I stated, were apparently completely ignored.

Senator COHEN. Let me ask you, did you go to your own physician, the one who had originally been treating your husband?

Mrs. KAGE. Yes.

Senator COHEN. And did you ask him to send in his reports?

Mrs. KAGE. I just read from that one, and also from the ophthalmolgist's report.

Senator COHEN. Did you send them before the determination was made to deny your disability?

Mrs. KAGE. We sent that after we had received notice that they were examining our case and they had requested doctors' reports from our physicians. We obtained these and sent them on back up. The doctors sent them right directly to the Determination Service.

Senator COHEN. Were you under the impression that you would have to prove your husband's disability again?

Mrs. KAGE. No. That was never stated.

In fact, right up to this point, until I heard it today, I was not aware of that fact.

Senator COHEN. That they would disregard the prior condition?

Mrs. KAGE. Right.

And I think when we're talking about a review, we're talking about a misnomer, because a review is of something that has already been. What we're talking about here is John Doe walking in off the street is doing the same thing as a person who has been on disability, as Dick was for 7 years. And they have completely erased everything that happened prior.

Senator COHEN. Well, that's exactly why I raised that issue, because most people, when the SSA says your case is under review, normally would assume—well, from where?—from where you were, to see whether your case has improved or deteriorated, and start from there.

In fact, the practice has been to just ignore what the disability was, ignore past medical records, and take into account only from the moment where the claimant or your husband was examined by the doctor.

Mrs. KAGE. I would say up to that time I had not heard about that.

As I stated, he worked on a survey crew. He was statewide, so he traveled all over the State of Michigan. Even after he lost the sight of his left eye, he maintained that job, although it was rather difficult for him. After he had his stroke, with tunnel vision, of course, he was unable to drive. He could not do anything. If he were sitting here, he would not be able to see this pitcher of water here. This had not changed; this remained the same. When they reviewed our case, he was exactly the same as he had been several years prior when it was first granted to us.

Senator COHEN. How old was he at that time?

Mrs. KAGE. When he first went on disability, social security disability? He would have been 42.

Senator COHEN. And when was it? 1981—was that 10 years later? When did he go on?

Mrs. KAGE. 1974. When we received the Notice of Review, it was quite a shocking affair for Dick. I arrived home from work, and he was in a very agitated state. He thought everything, you know, was going down the drain, that the plug had been pulled out. He didn't know how we would survive.

I think our first thought at that time is what kind of a system is this that can allow something like this to happen? If we had the system for 25 years or so, why all of a sudden are we going through this massive review? Isn't this something that should have been done on a continuing basis?

I grant you there are people who are on disability who do not belong there. And I personally know of some. However, this massive pinpointing now—why not over the years, in a systematic way? This has not been done.

We were on for 7 years and never any indication. At the end of the year we had to send in a report whether he had made any money that year from employment. And that's the only thing which we sent in every year.

Senator COHEN. Your husband was what, 50, when he died?

Mrs. KAGE. Forty-nine.

Senator COHEN. He had arteriosclerosis?

He was a diabetic since the age of 12? He was still on insulin, I assume, all that time?

Mrs. KAGE. Yes.

Senator COHEN. Plus the determination made about his tunnel vision, he also suffered from hypertension?

Mrs. KAGE. Yes. This was all presented to the Disability Determination Service on their review case. As I say, he was completely agitated and remained so; although I think, for the sake of the rest of us, he tried not to let it show.

Senator COHEN. I understand the SSA did, after Senator Levin's office intervened, at least restore the payments from the time they were denied, up until your husband's death.

Mrs. KAGE. Yes. I think the timeframe is most interesting, in that we received the notice of disability examination form on April 21. We received the notice of pending cessation form on May 14, saying that they were advising the Social Security Administration to cease payments within the 2-month frame. We heard nothing from the Social Security Administration itself until July 30, saying they were discontinuing our payments with the July payment. We had no previous notice from the Social Security Administration that they were accepting the report of the Disability Determination Service.

On August 10, I sent the reexamination request in. On September 25, I sent additional data in from the doctors to support our claim.

On October 8, I called the Social Security Office in Mt. Pleasant to find out—we had heard nothing—that they had received our request or anything at that time. Mrs. Wilson, in that office, said she would return my call after checking the file. I never received a call.

A week later, I then called the Social Security Office, and she said they had requested the file from Baltimore and as soon as it was received she would send it to Traverse City. She sent us additional forms that we needed to sign. I signed them and sent them back.

On October 30, I again called the regional office and asked what the status was, because we still had heard nothing, and she reported that the files had not been sent out from Baltimore. It was tied up in their computer process somehow, and they did not get the file.

All this time, we had been without any income, and at that time, Dick had been in the hospital. He had a toe that was gangrenous, and they thought it was going to have to come off. Fortunately, antibiotics stopped it at that time, so he only spent a week's stay in there.

I sent that additional information, also, to the Social Security Administration. By November 5, I still had heard nothing. That is when I contacted Senator Levin and our representatives for our district.

On November 25 then, we received another notice of disability examination form from the Disability Determination Service in Traverse City, setting another appointment with the same doctor in Mt. Pleasant, for another visual exam that we had gone through before.

Two days after that, Dick died. He took sick on Thanksgiving evening, and by 7 p.m. the next day he was dead. He had two massive heart attacks.

I talked to the doctor on Monday following the autopsy. He gave me the results, and the document was printed out. He said at that time that the pressures that he sustained, the stress from this cessation of benefits, was definitely a contributing factor to his death.

I called the Disability Determination Service to tell them that we would not be keeping the appointment and why, that Dick had died. They made no comment whatsoever. They just said, "All right," and hung up.

I think I would like to speak to that, because any time people are working with people and trying to be helping people, I think there could be a little compassion shown.

Through Senator Levin's work on our behalf, we received a letter from him, and a phone call at the end of January saying that our social security disability was being reinstated from the time that it was cut off until Dick's death. This was on January 29. We received nothing from the Social Security Disability Determination Service or anyone else until April 5.

Senator **Cohen**. Of this year?

Mrs. **Kage**. Of this year. Never did we receive anything that they had received the file, that they were working on the file, other than my phone calls to Mt. Pleasant, never anything that was instigated on their part, no correspondence saying "We have received your request and it is being processed." We got nothing.

Senator **Cohen**. Mrs. Kage, one of the reasons I suggested that perhaps it would be a wise policy to have a face-to-face interview at the very initial stage, is to try and deal with that very problem. It's something that's larger—and I mean this in a very sympathetic way—it's larger than your case. When the Social Security Administration talks about us as a society, we've moved to the age of the computer. All we have to do is just factor in the age, the amount of the benefits, and when they began, push a button, and out comes a sheet, and that's not good enough. Then, they say, "Here are 40 cases or 440,000 cases. Now, we're going to determine how many people should be continued and how many should be discontinued." Again, there's no face-to-face dealing with those people.

You look at the file and you look at the docket report. The docket report may conflict with the one which you began, but you never see the person. The effort to insulate the hearing examiner from the passions of the people, from—I guess the way it was phrased—the emotion, is the very process by which we continue to calcify our indifference. We just remove people from the process and deal with it on a file-by-file, number-by-number basis, and that's what happens. People like you and your husband fall through the cracks in the computer. That's what happens.

So, I think it makes a good deal of sense to try and have that initial face-to-face meeting on the first meeting, not on reconsideration, but up front, the first time, so that we have some connection that I'm dealing with you as a person and not simply as a number.

So, I would disagree with the proposal that we put it one step higher. We've already gone one step. We should start and make it at the very beginning. That's where the face-to-face determination ought to be, especially in a denial case.

I understand the administrative load which could be created. But in those cases, when you take something away that somebody has, there ought to be some kind of a face-to-face determination to make that assessment. Otherwise, most people will be treated the same way, because the system, the way in which it was designed, it's a large, loaded bureaucracy, like we have here in Congress. We don't deal face-to-face with people.

So, I hope that we can make some changes and will learn from your experience.

Mrs. KAGE. I guess the main question I have is why they disregard the physician who has treated someone for *x* number of years and two experienced physicians—very well qualified physicians, specialists in their field—why these are completely ignored and the doctor who sees a person for 15 minutes can make the determination that he is no longer disabled, and everything rests on that doctor. So from our own personal experience, I would have to fault the Social Security Administration on their response to Senator Pryor's questions concerning family physicians or their own physicians, because it's been our experience that the family physicians, even though they were specialists in their field, were completely ignored, and a 15-minute exam by the Government physician is the one that is considered.

If you have any more questions, I'll do anything I can. Our family survived by the grace of God, and it was through our faith and the presence of the Holy Spirit that we were able to maintain, and I think perhaps that's why I'm here today, because as I say, anything that anybody can do, they certainly should speak up and do.

Senator COHEN. You've been a very fine witness and we appreciate your coming and discussing this as you have. I think a lesson can be learned by all of us. That's one reason that we asked that the members of the Social Security Administration be here and listen to you so they can learn from the mistakes that were made in the past.

One brief comment about something Senator Levin has touched upon with some very eloquent words that he offered, and that is: What is the nature of the relationship between the citizen and the Government?

You find out it's adversarial in nature, or quasi-adversarial, as a legal term. In workmen's compensation cases you have a similar situation with the claimant who claimed that he injured his back in the workplace, and he would go before a workmen's compensation board and the insurance company always had its doctor, and all that insurance company doctor did was work for the insurance company. He spent 10 or 15 minutes being reviewed in these periodic reviews, and the burden would be upon the employer to show that that person's condition had changed, so you'd have to go and be examined by that company's doctor, the insurance company's doctor. But at least you had an opportunity to have your family physician say, "I've treated this person over the years," and usually the workmen's compensation rules gave greater weight to someone who has treated somebody, a doctor who has treated somebody over a period of time, than they do to an insurance company doctor who has seen him for a few minutes.

But you understand at least the term—you understand the nature of the relationship when you are going in. It's the workman against the company. It's an adversarial process, which you don't expect. That's why I think it's so important that the letter to you be very clear about what you're up against, and what you've got to do is to prove your case. The burden is going to be upon you, and you'd better come prepared; and that letter doesn't do it.

That letter says your case is under review to see whether or not you're entitled to continue under the program. That, to me, conveys an entirely different relationship. So I think the first thing we ought to do is to be more candid, even at the risk of terrifying you, even at the risk of causing you anxiety. You ought to be informed, so you can be better prepared.

Second, I would hope that it wouldn't be as adversarial as we have seen it to be, and that what Senator Levin was saying about having some passion in favor of people as opposed to simply denying them would apply, and maybe that will come out of the same——

Mrs. KAGE. I would like to say that when the Social Security Administration says they don't want to terrify people, I think they're demeaning the public out there. When you receive a letter—if you receive a letter saying what was going to be done, how it was going to be done, I think that's an insult to my intelligence anyway, that I will be terrified by a letter saying how they were going to do something. I really take offense at that personally, because I think it's a very demeaning statement on their part, that the general public out there are just a bunch of slobs who, you know, have to be kept in the dark, and I find that very belittling.

Senator COHEN. Senator Levin?

Senator LEVIN. First of all, Mrs. Kage, I add my thanks to those of Senator Cohen for coming today. You've been a tremendous witness. You've gone through a lot of suffering, and it's important that you share that so that others can avoid what you had to go through, and we thank you for that.

Second, the files of the Social Security Administration confirm everything that you've said. We won't have to press you too much on details.

Third, let me just expand a bit on what Senator Cohen has just said, what he's pursued this morning in terms of that original letter, pointing out that that original letter doesn't tell you what is happening to you, and indeed it doesn't. It keeps you in the dark, as you have just said. It treats you like a child, to your own detriment, because ultimately what's happening to you is that you're in the process of being cut off the rolls. You're to be considered no longer disabled, in a vast number of cases without any adequate medical examination. That was what was happening to you. What's also happening is that you're going to have to prove all over again that you're disabled, and you're not told that, as Senator Cohen has pointed out.

Now, what's also happening, not only are you not told that you're going to have to prove all over again that you're disabled, but what also happens is that you're going to have to prove it according to new rules. The game is being played not according to the rules that were being played at the time of the disability determination, but according to new rules, and that's a fundamental unfairness as well.

Finally, after all that is done to you without adequate knowledge, you may then appeal, and most of the people who are wise enough or informed enough or whatever to appeal, or are alive to appeal, are going to win. But during that 9- to 12-month period of that appeal, they're going to lose and they're going to lose hard because they're going to be cut off the rolls and benefits will not be paid during that period of appeal, although two-thirds of the people appealing are going to win.

I can't get that fact out of my craw. No Government, it seems to me, should tolerate that kind of injustice. It's a massive injustice.

What happened in your husband's case now, according to the doctor, it seems to me, is overwhelming, and I want to just read that line, although it hurts. I'm not a doctor, but let me read what a doctor said, and doctors don't say things like this very easily. He says, after your husband was notified that he was now capable of working and in the process of attempting to do so, and under the stress created by the termination of his disability benefits, Mr. Kage had an acute myocardial infarction and died.

Now, I've seen a lot of doctors in a lot of courts and know doctors do avoid testimony about causation. They do not readily reach those kind of conclusions. This is a conclusion which the doctor wrote in a letter to the Disability Determination Service, which should be made part of the record as to exactly what it is we're talking about in one case. Multiply this by hundreds of thousands of cases and we have an added dimension; but in one very real case, most real to you, you're familiar with it, we have a doctor that said that under the stress created by the termination of his disability benefits and attempting to work because he was totally incapable, he had a heart attack and died.

One other—this doctor says, and his rage comes through the letter not as well as it would in person, but my gosh, he said in one letter here, if I can quickly find it, he says the termination of the disability determination by a bureaucracy that can't possibly function in an honest and ethical function, as he put it, is obviously disturbing to him. And then he said, "I don't care who up there realizes that I feel this way. I will say it now and I will say it publicly, that this service is a disastrous failure. I don't care who up there knows it."

Mrs. Kage. He was very frustrated. He'd been very supportive through our whole process. In fact, I'm not certain whether it was in that letter or the other letter that you have a copy of that he wrote to the Determination Service asking them to call him or contact him if they had any questions or if he wanted anything further that he could do, and he had never received any call from them, any correspondence from them. I talked to him just before I came to Washington.

Senator **Levin**. I think these letters should be made part of the record, not just as to what they say as to a specific case, but also because of the frustration and rage that's reflected in here by a physician.[1]

Again, people are on these rolls who shouldn't be there. I don't think we can defend sloppiness. But the way to cure sloppiness is not through the imposition of massive injustice and that's what we've done, and that's what we've got to stop. We want to get people off the rolls who don't belong on the rolls, but with equal fervor, we want people on those rolls who do belong. That's the purpose of the system, and your being here today is a very eloquent example of a system that's gone haywire, and again we thank you.

Mrs. **Kage**. As I said before, I'm just happy that I was able to do it, any small thing that I could. And one small item about the loss of benefits, during the appeal process the people who are on disability aren't making that much money that you can set money aside, that you have any kind of savings or income to support you over that time limit. So when your disability is discontinued, you're at the edge. I mean, you have nothing to fall back on to hold you over those months that it takes, and I think that is never taken into consideration. There is no leeway. When you're at the end, you're at the end, period.

Senator **Levin**. By the way, would your husband have liked to have worked, if he could?

Mrs. **Kage**. Would he have liked to have worked? Very definitely. He sat home for 7 years and being confined, I mean, he couldn't even walk down the road because he would not have been able to see cars coming.

Senator **Levin**. Did it hurt him that he couldn't work?

Mrs. **Kage**. Did it hurt him?

Senator **Levin**. That he could not work?

Mrs. **Kage**. Yes, it was very frustrating to him. It was frustrating to him that he couldn't do—well, he just couldn't walk by himself, you know. If we would go shopping in malls or anything, we would have to walk one on each side of him because he was terrified that a little kid was going to run in front of him, a small child, and he would not be able to see him, you know, and knock him down or something.

Senator **Levin**. Thank you.

Senator **Cohen**. Thank you very much, Mrs. Kage.

Our next witnesses are Kathleen Grover from Portland, Maine, and Jonathan Stein from Philadelphia. Ms. Grover is a private attorney who has handled a number of disability cases and Mr. Stein heads a project of the Community Legal Services of Philadelphia which specializes in disability cases.

Mr. Stein and Ms. Grover, I know you've been waiting for a long time and very patiently, but if you could summarize your testimony as much as possible, we're going to try and finish by 1 p.m., and we've got one more witness panel to follow you, so summarize as best you can.

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[1] Letters appear on pp. 421–424.

## TESTIMONY OF KATHLEEN GROVER, ESQ., HOLDER & GROVER, PORTLAND, MAINE; AND JONATHAN M. STEIN, ESQ., CHIEF OF SPECIAL PROJECTS, COMMUNITY LEGAL SERVICES, INC., PHILADELPHIA, PA.

Ms. GROVER. I will.

I feel that the major problem is the standard under which the reviews are being conducted. The present review system does not comply with due process requirements, and it is not an adequate review of the determinative issues.

The Social Security Act and regulations define disability as a mental or a physical impairment or impairments which result in total inability to perform substantial gainful activity. The initial two levels of review done by the State agency are done only on the basis of whether or not the individual's physical or mental condition meets the criteria of a particular requirement as listed in the regulations. There is no consideration given to medical opinions or other evidence which indicates continuing disability and inability to perform substantial gainful activity if that evidence does not directly bring an individual within a specific listed impairment.

This is true despite the fact that the Social Security Act and regulation can demand consideration of a broad range of vocational and medical aspects of the claim. It is only when an individual's case reaches the Administrative Law Judge that it is fully and adequately reviewed in accordance with the Social Security Act or regulations. Thus, two sets of rules have been used.

It's also a waste of time and effort. There are two major groups of claimants adversely affected by the application of this old restriction standard. They are persons suffering from back conditions and multiple impairments. What seems to be the problem in the area of back disabilities is that, as you can imagine, many of these disabilities are not easily diagnosed. The state of the medical art in terms of diagnosing the treatment of back conditions is somewhat limited. It simply is not possible in all instances to obtain clinical and laboratory findings to support a specific diagnosis.

Oftentimes, chronic, intractable, disabling pain is not evident in X-ray or laboratory evidence. The State agency has specifically informed me that they do not accept pain as a disabling condition because it is not contained within the list of impairments. A person with a back injury must have one of those specific injuries listed within the impairment in order to be found eligible for benefits.

A particularly glaring case is that of a 36-year-old gentleman who has had three disc operations on his back. None of them have been successful. At the present time, the only medical evidence in this claimant's file is from the treating orthopedic surgeon and the neurosurgeon who performed the consultation. Both physicians claimed him to be totally disabled with a very poor prognosis and neither one recommends any further treatment. Based solely on this medical evidence, the claimant has been denied continuing benefits.

The list of impairments also fail to deal with persons who have multiple severe problems, none of which are in the specific listing but when taken together cause the person to be totally disabled. These people simply cannot be fairly adjudicated under the list of impairments, and yet at the first two levels of review, that is the only criterion applied to determining the degree of impairment. These are the people who will never fit within the list of impairments and the strict instructions listed by the State agency. They will always be terminated from benefits when their claims are reviewed. In most instances benefits will be reinstated, but only after pursuing the full administrative procedure. This process means an average of 10 to 18 months without benefits.

A striking example is a middle-aged woman who suffers from residuals from a stroke as well as a heart condition and circulatory problems. Again, the only evidence in the file was from the claimant's treating physician, who stated that the claimant was totally disabled and that the condition had deteriorated during the period of review. This claimant was denied benefits until she appeared at the hearing. She was without benefits for 20 months, during which time she lost her home and car because of her inability to remain current on payments. This woman's disabling condition stems not from one impairment but rather from several, no one of which meets the criteria on the list of impairments. Because she is disabled by many, rather than one impairment, she will never be found disabled at the initial two stages of review.

It has been my experience that many claimants who suffer from multiple disabilities are less able to perform substantial gainful activity than those claimants who have one severe impairment which meets the criteria of the list of impairments. The person with multiple impairments is foreclosed from many avenues of accommodation which might be available to persons with only one impairment.

As might be expected, persons with a severe mobility problem can often compensate by using sensory and mental skills in the job market. The individual who has a moderately severe back condition or mild mental retardation and a hearing deficit has far less options, yet is deemed not disabled because no one condition meets the criteria of the list of impairments. The number of these people is significant, and they are being penalized by a review system which fails to adequately examine the issue of disability. This constitutes a violation of due process as these claimants are being denied adequate opportunity to be heard. The opportunity to present evidence is a hollow gesture if that evidence is not going to be reviewed in an appropriate manner.

Persons with psychiatric disabilities are confronted by an additional dilemma in that the State agency has not shown itself to be competent in applying its own standard. In a too common example, one of my clients was denied continuing disability at the State level. When his case was forwarded to the Office of Case Appeals, a decision was rendered on the record. Medical evidence from the treating psychiatrist was sufficiently clear that a hearing was totally unnecessary. The only way that such a decision could be rendered is if the medical evidence alone is competent to determine that an individual meets or equals a listed impairment.

This is exactly the sort of decision that should have come from the State agency. However, prior to the decision they advised that they weren't able to do this. They required the administrative law judge to review the record and make that decision.

The fact that the State agency was not capable of rendering a decision on the basis of that same evidence indicates an inability to make the correct decision, even with the facts that are absolutely clear.

I would again remind you that if there is any conflicting or inconsistent medical evidence, a hearing must be held to resolve those issues. The fact that neither of these were necessary in the above case indicates that the record was complete and the claimant was clearly disabled, but the State agency is simply unable to perform their duties properly.

At this time I would like to recommend some suggestions for possible improvement of the system. I would strongly recommend that the Social Security Act, as it relates to determination of benefits, be amended to include the presumption of continuing disability, leaving the burden of proof on the administration to show that the disability no longer exists at the same level of severity.

And then it should further clarify that such disability be defined by the prior determination to grant benefits; that is, if the administrative law judge in a prior decision has determined that a claimant's multiple disabilities are the basis for entitlement, those same disabilities must be presumed totally disabling.

It would then be the administration's burden to show that all or some of these conditions had improved significantly and hence resulted in a nondisabled condition. It is important to spell out that claims were not to be subjected to review under the criteria of the listed impairments, while in the prior decision they have been found totally disabled under additional criteria.

If the standard of review is not changed, many persons will be subject to long and difficult appeals. The mandatory review process should only continue if claimants are offered a competent review of all the pertinent data and not merely a partial review.

In summary, we have a review process which does not adequately deal with the issue of disability. The process is slow and cumbersome, requiring legal representation and great expense, both to the administration and the claimant. Because these claimants are for the most part without alternative income we are causing extreme hardship and suffering to those least able to protect and defend themselves. We have singled out the weakest and the poorest in our society and imposed on them an almost insurmountable financial and mental hardship.

Although we are discussing these issues in light of the review process, I would like to remind you that these same problems exist for those persons making an initial application for benefits. We are talking about a significant number of people who are truly suffering because the administration and the eligibility policy, both in initial decisions and in the review process, is inaccurate.

I would like to thank you very much for this opportunity to present my views. I feel very strongly about these issues because I am daily faced with clients whose lives are devastated by the mechanical decisions of the Social Security Administration.

Senator COHEN. Mr. Stein.

Mr. STEIN. Senator Cohen, I am Jonathan Stein, chief of special projects of Community Legal Services in Philadelphia, where I have practiced law for low-income and disabled clients continuously since 1968, and where, I hope with Congress' support, we will continue.

The arbitrary termination since March of 1981 of over 175,000 people on SSI and social security disability has become a national scandal and demands the most prompt of legislative remedies to reign in a lawless and heartless Federal agency.

In my current position, I represent many disability clients individually and in a class action litigation recently filed in Pennsylvania, *Kuehner* v. *Schweiker*, C.A. No. 82-1839 (E.D. Pa.), representing over 250,000 SSI and SSDI beneficiaries. In addition, I am in contact with scores of legal services advocates across the country and many scores of private attorneys who have also called, relating to me and our office their problems.

Contrary to the line Social Security Commissioner Svahn is offering Congress, there is a clear pattern of abuse and errors being made. We would conservatively estimate that 90 to 95 percent of all CDI reviews leading to cessation are clearly erroneous decisions which no one on this committee would ever sanction.

Moreover, the 5 to 10 percent of the others we believe are close judgment calls, in any event, which nevertheless are not being fairly decided.

The prime causes of this scandal are the unprecedented combining of three factors. First is the impossible volume of cases being pressed on State DD agencies, currently 30,000 new reviews a month, to increase next year.

Second, are longstanding systemic weaknesses and failings in the Federal and State disability processes, ignored for years by Congress and now suddenly painfully visible as hundreds of thousands fall victim to these long-ignored administrative failings.

Third is an undeniable effort by the current SSA administrators to save money on the backs of the disabled by changing standards of determining disability, accomplished quite secretly without any congressional sanction nor with any notice and public comment rights offered to the public to scrutinize what, in essence, has been agency sub rosa amendment to the Social Security Act, and properly promulgated regulations.

The mandate of the 1980 amendments to review these cases in a relatively short period of time, in addition to the hundreds of thousands of regular applications, is simply an impossible task for any State DD agency.

The entire justification for the CDI requirement has erroneously been called a GAO study by Commissioner Svahn. In reality, it was a social security study of a small number of beneficiaries, which cannot be assumed to be objective and independent of bias.

Moreover, the report's conclusions on the ineligibility of a minority of beneficiaries has never tested the number of supposed ineligibles against whether the initial decisions concluding they were ineligible would be upheld on appeal.

And, as we have repeatedly heard this morning, the reversal rate of 67 percent or more, and then over half of the rest succeeding in Federal court, suggests that any findings or any study put forward by Social Security must be highly suspect and unreliable.

We urge Congress to reconsider and repeal these mandatory reviews of all cases and review a much smaller number where a substantial medical improvement is both probable and can be proven to justify cessation.

Specifically, these high volume of reviews have had the following effects:

One, cursory review of evidence. The State adjudication process can only be described as arbitrary and completely failing in due process. The Pennsylvania Office of Vocational Rehabilitation, which oversees the DD agency in Pennsylvania, has called the process "dehumanizing and frenzied." And they admit in the report which we filed with the staff that they could not possibly meet the demands of the 1980 amendments.

Although the adjudication theoretically has all the prior evidence available, in practice they ignore all the evidence but the most recent consultative examination.

The CE, the one-shot medical exam given by a doctor who has never seen the beneficiary before and who rarely has any medical history, is made mandatory as a matter of SSA policy, and the majority of all CDI's will utilize CE's, the number to increase unfortunately.

Despite congressional hearings this past fall in House Ways and Means, SSA has imposed no controls on the use of so-called high volume consultative examiners, high volume providers. They refuse to provide CE doctors with complete prior medical histories, and they appear blind to a pattern throughout the country of the most abbreviated and shoddy examinations at fees which, in Pennsylvania, are at a maximum fee of $35 per examination.

So inadequate are these fees that ALJ's regularly across the country discount them entirely as useless and unreliable, yet the DD agency solely uses them to make their decisions.

That brings me to my second point, that of ignoring the treating physician evidence.

Senator COHEN. Excuse me, Mr. Stein. Do you have any studies which show the average length of the examinations?

Mr. STEIN. No, but we have enough individual cases. There are enough 10- to 15-minute exams or 5-minute exams to make a very distressing kind of point. We have a psychiatrist who regularly sees people in Philadelphia who can hardly speak English, and the whole exam is verbal; claimants continue to complain to us and to the State agency that she doesn't understand them. Yet she continually reviews people for psychiatric impairments with very abbreviated exams, 5 to 10 minutes, in public areas, not even in a private waiting room.

That, I think, is representative of the quality of many CE's. But even if you have an adequate CE, the State agency has its own standards by which it is deciding these cases, and many CE's who are reputable, conscientious physicians are enraged that their findings of total disability are being ignored by the State agency.

Which brings me to my second point, that the State agencies, under guidelines from SSA, are totally excluding treating physician medical evidence. The high volume of cases causes the State adjudicators to cut corners and not even to seek out such evidence.

An example in Pennsylvania is a policy that they won't even write to VA hospital doctors to get evidence. In one case, Robert Astrove, a 60-year-old client, a World War II veteran, with multiple disabilities, including severe arthritis, angina, high blood pressure, diabetes, and a psychiatric condition, had two treating physicians at a VA hospital, a neuropsychiatrist and an orthopedist. He found out that the DD agency wouldn't even write to them because if they did, their explanation was, the processing time was so severe on them that they couldn't wait to get treating physician evidence from any VA doctor.

So as a matter of policy every veteran being reviewed in our area would be subjected to this policy. Their treating physicians at VA are simply ignored!

We have heard, of course, this morning Mr. Simmons gloat over his processing time goals, but he never revealed at what cost those goals resulted.

In addition, evidence that goes back beyond 3 months is not even considered current, so they have their own built-in policy excuse not even to go back into medical history.

SSA continually falls back on the lame excuse that the claimant has the burden of proof to prove disability, and, as we just heard a minute ago, the remedy for changing this for those who have been on disability is establishing a presumption of continued disability. One of our circuit courts, the Ninth Circuit, and perhaps others following, in a recent case, *Patti* v. *Mathews,* has said that there is, in current law, a presumption of continuing disability.

Despite this burden that is put on the claimant, the Cessation 1 notice used by SSA gives as their "due process" but 10 days to obtain additional medical evidence, making it virtually impossible for the beneficiary to obtain this evidence. Moreover, the very physical and mental disabilities of the claimant, plus his dependence on overworked medicare and medicaid doctors, make it grievously unjust for SSA to put the burden of proving disability this way upon the claimant during the initial review procedure.

Currently, this is a policy in the POMS, which is the Program Operation Manual System—I will say a few more words about that in a minute—does not even mandate that the treating physician evidence be fully developed and complete in the file before a cessation is ordered. When treating medical sources are sought, the State DD agency never informs the treating physician what is required. They never give him a list of impairments. Thus, they hide the ball from the treating physician. And when the reports, quite understandably, come back in summary form or in incomplete form or in a form simply concluding the obvious that someone is totally disabled, that report as a matter of policy is totally ignored. They instruct their staff that they should not give it any weight and that they should exclude that report from the treating physician. A real irony.

Finally, SSA and DD agencies fail to afford to treating physician reports the binding effect and great weight our Federal courts have uniformly held is required of them in relation to these one-time consultative exams.

Because the HHS Secretary and the Commissioner of SSA have repeatedly ignored Federal court decisions, particularly in this area of treating medical source evidence, and the clear value that Federal courts for 20 years have been giving to this evidence—understandably so, as it comes from doctors who know the patient best—

we urge Congress to amend the Social Security Act to require a full development of treating medical evidence for the immediate past year before any decision to cut someone off is made.

We add in language which we have suggested in our formal testimony that the Secretary must afford such treating physician evidence weight greater than that given to any CE exam they administer.

I might add just one thing. We are talking about CDI reviews. We haven't talked about initial applications. And the committee should be aware that the current administration has the highest initial denial rates in the history of this program. Seventy percent or more of everyone who applies initially are being denied. And if Congress will amend the act to cover continuing disability reviews and require treating physician medical evidence to be fully developed before, we also suggest that that be applied to initial applications.

My next point goes to the fact that, as a matter of policy, medical improvement is deemed unnecessary to be proven by Social Security. Up until 1976, Social Security had a very commonsense and reasonable burden placed in these cases for them to show that a beneficiary had medically improved as a prerequisite to a cessation decision, but this past regulation which had found repeated confirmation in the legislative history of the act for 20 years—and we cite this in our testimony, going back to 1960, up to 1980—this policy was deleted in a very secretive, typical move of Social Security, when in 1976 they dropped this medical improvement policy. Yet it took them 4 years to announce it publicly in the Federal Register.

Thus, Social Security set the stage to treat every single disabled beneficiary up for CDI review as merely an applicant applying for the first time, legitimating their ignoring of the entire medical history of that beneficiary.

Not surprisingly, as soon as they dropped this requirement in 1976, the CDI cessation rates increased. They were 16 percent in 1975. In 1978 they have gone to 50 percent, as a House subcommittee report shows.[1] We have, in addition, a formal Social Security ruling that now makes it formal as of January 1981, that "It is not necessary to show that the individual's medical condition has improved since the prior determination."

Then we have Mr. Hays, who was sitting here before, directing all his administrative law judges to ignore a Ninth Circuit Court of Appeals decision called *Finnegan* v. *Mathews,* even in the Ninth Circuit, which required a showing of medical improvement before cessation. We attached the ruling and also that February 1982 memorandum from Mr. Hays—a shocking memorandum, I might add—to my testimony today.[2]

SSA's continuing refusal to show substantial medical improvement before cessation perhaps best shows how they wish to push people off disability via this assembly line process. Mass volume reviews and the desire to save money have made SSA more insistent in defending its "we don't care if there is no medical improvement" policy.

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[1] "Subcommittee Survey of State Disability Agencies: Adjudicative Climate," House Committee on Ways and Means, Subcommittee on Social Security, WMCP:96-5 (Feb. 1, 1979).

[2] Memo referred to appears on p. 279 as an attachment to written statement of Eileen Sweeney, of the National Senior Citizens Law Center.

Yet our Federal courts are beginning around the country to demand that they show medical improvement.

And a class action we filed in Pennsylvania and another in Vermont and another in Oregon, evidence that, because we don't see any willingness of SSA to voluntarily change it's policies. We further suggest that Congress amend section 223, subsection (d) of the act to require that there be a showing that substantial medical improvement has taken place in the disability or disabilities of individuals, or where newly discovered evidence shows that the original decision was clearly erroneous. I might add this would also be the place to add my colleague's suggestion of having that presumption of continuing disability be explicit in the statute.

An additional point we found in seeing these cases around the country is the total ignoring of vocational factors and changing the program into a medical listings program without any OK from Congress. As the committee knows, unlike the widows and widowers disability programs, SSI and SSDI require an evaluation of vocational factors, when a beneficiary has an impairment which can't be said to meet or equal one of the listing of medical impairments. Thus the residual functional capacity, including the age, education, and past working experience, must be looked at. Yet under the pressure of this mass volume of reviews, we see a clear message going out from Washington and Social Security, which is to focus solely on the medical listings and to ignore vocational factors by solely comparing the recent CE examination with the medical listings and the nonpublished interpretations of them, given exclusively to State DD agencies and never appearing in the Federal Register.

There is a most serious question whether the recently touted vocational guidelines grid set up to streamline cases—and is supposed to benefit more elderly people—has ever been used by any State agency.

Typical of this ignoring of vocational factors is the case of Frank Jennings in Philadelphia, who had bone cancer and a leg amputation at the hip, which placed him on social security disability for 9 years, since the early 1970's. Despite his illiteracy and failure to complete the second grade, prior job experience only as a laborer, continuing treatment for bone cancer, and lack of a usable prosthetic leg, he was informed this past February, by the Pennsylvania agency, "You can be expected to adapt to other work." And he was terminated without any inquiry into the vocational effects of his disability and despite his treating physician's letter saying that he would be impaired indefinitely.

A 58-year-old World War II veteran named Raymond Stankiewicz, with severe cervical spondylosis, degenerative joint disease, arteriosclerosis, and digital artery occlusion, had a condition so serious that he was hospitalized for weeks in Philadelphia during February and March 1982 for surgery. Yet during this same period, he was being reviewed and terminated by Social Security, as soon as he got out of the hospital.

And we cite some additional cases where it's clear that vocational evidence is totally ignored. We also have found that nonexertional medical impairments are totally ignored, despite the fact that regulations provide that they must be looked at.

And what we uncovered here is really a whole other secret area of law in operation. We found that there are two standards that exist: one, the statute and regulations, but what is also going on is the use of unpublished instructions in the Program Operations Manual System [POMS] and in the Informational Digest and other circulars which tell the State agencies how to decide cases completely contrary to the act and regulations. One of the best examples is the mental impairment area, and we cite examples of people with extreme psychoses of schizophrenia who are being regularly terminated for disability. One client with severe depression was hospitalized in a mental hospital for 2 months while she was being reviewed. She has said, "The State should build gas chambers for people like me." A very pathetic, sad case, yet while she was in a psychiatric hospital, she got her cessation notice saying that she had the ability to return to work.

One last case, Mara Park, found walking the streets of Philadelphia with schizophrenia, no money and no medical care. She lost her disability benefits without even receiving notice of a CDI review. No one, it appeared, ever considered that a personal contact was mandatory with a schizophrenic.

An additional point goes to the fact of ignoring pain. I know the committee has heard a great deal about this, but what I'd like to emphasize here is that pain is currently required to be looked at under SSA regulations. Pain is also required to be looked at by almost every Federal court for 20 years that has looked at a pain case, yet 2 years ago, in the POMS, the section on the evaluation of pain was simply eliminated with no public notice, no publication in the Federal Register, and no revision of the Federal regulations on pain. And the cryptic instruction left with that excision was, "Deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed."

We have that appended to our testimony.[1] As a result of that little excision made in Baltimore or Washington, we have not seen one case ever in the last 2 years or even longer than that, where pain was recognized in whole or in part as a basis to award disability benefits.

To make matters worse, the so-called "Pickle bill," H.R. 6181, which is a seriously deficient bill, would impose, under the rhetoric of uniformity, these POMS on the entire system in section 7 of that bill which would require "uniform standards to be applied to all levels of adjudication." That seemingly benign change would simply give Social Security the power to impose these POMS on everyone in the agency, especially the independent adjudicators, the administrative law judges. And as we've heard this morning from Messrs. Simmons and Hays, they have plans under way to already do that, even though they're not even going to wait, apparently, for a congressional OK of this. They're going to go ahead via Social Security rulings without any Federal Register publication. I think that needs some immediate addressing by Congress.

In terms of the appeal system SSA is trying to have it really both ways on appeals. On the one hand, in Commissioner Svahn's letter to "The New York Times," which I understand was distributed to all Members of Congress, they praise the appeals system as correcting the many horror cases published in the media and say that this adequately safeguards individual rights. They bless the appeals system on the one hand, yet, on the other hand, as we heard this morning, they scapegoat the ALJ's. They blame them for making erroneous decisions. And we think the scapegoating will escalate as the CDI's continue, because if they continue, if this committee and Congress allow them to continue, tens of thousands of more appeals will take place, and they'll continue to blame the judges for making erroneous decisions.

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[1] Retained in subcommittee files.

Among the problems created in the appeals systems by these mass reviews are delays, and the ultimate delay will be 2 years down the road before the CDI is corrected. Currently, it takes 3 months to get a reconsideration decision, which is a needless rubberstamp decision of the initial denial or cessation, which we think is a step that ought to be abolished. It's the same people, essentially the same agency making the decision, but you have to wait 3 months to receive your rubberstamp decision there. Then it takes up to 6 months to get even a hearing scheduled before an ALJ. It takes 3 or 4 months then for the decision to be rendered. And because of these Bellmon reviews, judges are forced to write out in great detail decisions where, in the past, in clear-cut cases, they rendered very brief decisions in 24 to 48 hours.

So we're waiting 3 to 4 months for detailed decisions, and then something that's not been mentioned, you have to wait up to 6 or 7 months to get the hearing decision effectuated, because the reviews and the bureaucracy and redtape of getting the decision out. Thus it's at least a year to get the terminated person a hearing, considerably more to get the person back on. Yet we're finding that two-thirds of people terminated are getting their CDI cessation reversed at hearings. This is at a time when there are already 175,000 ALJ dispositions this past year. That's bound to worsen if the CDIs are permitted to increase.

We're seeing the quality of ALJ decisions suffering, and these are with very conscientious judges, generally, who work pretty hard at their jobs, but yet with this onrush of cases we find that they're not getting additional medical evidence that the courts require them to do to do the work that the State agencies should have done much earlier.

Senator COHEN. Mr. Stein, let me ask you a professional question. Do you find administrative law judges to be less skilled in determining the existence of disability than perhaps State-trained disability evaluators?

Mr. STEIN. No. I think the ALJ's are, for the most part, extremely skilled, experienced lawyers. Many of them have done workmen's compensation practice, as apparently you did, Senator. They did negligence work. They probably are a unique cadre of judges who have the skill to handle these cases. So I think the testimony you heard was testimony speaking to training, which I might call brainwashing, essentially, specifically, very narrow training directed to staff as to how they should decide cases. And if you add up the weeks that Social Security gives judges and the DD people, probably they're roughly equal. But what was ignored was the years of experience in handling cases as lawyers and as judges in other capacities, entirely lacking among State agency staff.

The proposals that the committee has heard to improve the process, both in the so-called "Pickle bill," H.R. 6181, and by Mr. Simmons this morning, would do very little to improve the situation. Among the provisions of that bill that will make things even worse than they are today, are provisions in H.R. 6181 to close the record to new evidence after the reconsideration stage, that is preventing an ALJ from hearing new evidence and putting an impossible burden on uncounseled claimants, and most are uncounseled at that initial determination and recon stage. It will impose upon them this impossible burden which they clearly are not going to be able to do.

Congressman Pickle's intent, I think, was well-meaning. Essentially, he was seeing what an awful stage the DD process was in, and how inadequate the record was in developing medical evidence, but the remedy he came up with for this, putting an arbitrary line at a point in time after the recon stage when you can't submit new evidence, is very arbitrary, and I think, although well-intended, a misguided response to the problem.

Senator COHEN. Can I inquire right there? I have not really studied that point, but I think what Congressman Pickle was trying to get at, and I intellectually would agree with, is that if a determination is made that you were going to have your disability discontinued—this is the assumption that I make and apparently is not made by others—assuming there has been a full presentation of medical evidence at that point, the problem is that there's no full presentation of the evidence at that point, but ordinarily if benefits were denied, one shouldn't be allowed to then say, well, I have a new condition, or it's deteriorated further. That shouldn't affect the ALJ decision. I think what Congressman Pickle is saying is, if you have other conditions that change between the time of the initial determination, that shouldn't be the cause of reversal for the original decision. We ought to stick with the medical evidence. But if you can show, that your own physician's examination was not considered, if it was not detailed, if it was not a thorough examination, I don't think Congressman Pickle wanted to exclude that from being considered.

I think what he was trying to prevent is a decision being made at the State level, and then 6 months later, you start producing new medical evidence of a changing condition, in order to reverse that original decision. I think that's what he was trying to get at.

Mr. STEIN. I think, as I say, he was well-intended, but in reality you're not going to get, even with the changes in H.R. 6181 and a face-to-face reconsideration which is interesting, not a face-to-face initial determination, you're not going to get an adequate medical record put together for a host of reasons: The disability itself inhibits the person, many people don't have lawyers, the same people, the same DD agencies, which have an awful track record of securing medical evidence, will be the same people doing the reconsideration, et cetera. So the faith that people have in the system improving so much that you can arbitrarily cut off new evidence, I think is very misguided.

Senator COHEN. Let me go back—let's go back to try and give some sanity to the system. If we accept Miss Grover's recommendation, which I think is a good one, that if the Government is going to terminate something, let the Government bear the burden of proof, notify people what's really at stake here, putting people on notice rather than allowing them to be misread or anesthetized into some sort of comforting situation and then their benefits are suddenly gone—if you make those fundamental changes and say the Government is going to undertake a review, meaning an attempt to reject your claim, that we will bear the burden of proof, but you'd better come prepared with your medical evidence, it seems to me that's the way we ought to address the problem, and not say somewhere down the line infinitum, we're going to continue to take new evidence. What we ought to do is reform the system. The system ought to be reformed in such a way that you shift the burden of proof to the Government where it belongs. You're going to have to tell people exactly what you're about and not do it through soothing.

Mr. STEIN. Senator, I think there's a logic to what you're saying, but why don't we reform the system first and see if we're really improving the quality of decisions and securing of medical evidence at the initial stages, and if that is working, then we can go on to deal with cutting evidence off at the ALJ stage. Let's not make these changes at the same time, we and people across the country have absolutely no confidence in this system, because of its track record of being able to do an adequate job at the initial stages. If we're going to have an arbitrary time requirement, let's wait until the system has a track record of improvement.

Senator COHEN. But if we do an adequate job on making an initial determination, until recently we were doing an adequate job for the people who were filing their petitions and having their disability claims allowed. It's adequate there.

Mr. STEIN. I'm not sure it's been adequate. I think we've found that the ALJ's have been the only part of the system that have corrected errors at the lower levels, and we view this provision as an undercutting of the ALJ's ability to make lawful, equitable, proper decisions by preventing them from hearing evidence that they should be hearing, and until the rest of the system can get its act together and improve, you should not undermine their very salutory rule.

Senator COHEN. Historically, if you could supply it for the record, what has been the record of those cases being denied at the administrative law judge level, or overturned by the administrative law judges? That would be helpful.

Mr. STEIN. In which cases?

Senator COHEN. Initial cases, filing of disability claims.

Mr. STEIN. I'm not sure whether we have it precisely in initial cases. I think there's over 50 percent average reversal rate by ALJ's, which includes both continuing cases and initial cases.

Senator COHEN. I really would like to get at the point that you're suggesting, that they're really not competent on the initial level, and you've got to depend on the administrative law judges.

Mr. STEIN. I'd like to defer that to Judge O'Byrne, who will be speaking shortly. I suspect there's a high percentage of initial application that on appeal are reversed by ALJ's. Another provision—and Senator Cohen, I have in mind what you said earlier about the system being turned into an adversarial system—not in H.R. 6181, is called an "adversarial experiment system" by us, because what it would do would be to give SSA a representative, at an ALJ hearing and would turn that hearing for the first time in the history of the system into an adversarial one, which neither Congress or the courts have sanctioned or permitted. This idea was floated 2 years ago. Public outcry killed it, but interestingly we find that SSA has revived it and plans to try it in four cities in the next few months.

Senator COHEN. Let me interrupt you once more, because I've got to go to another meeting.

Mr. STEIN. Let me just say, I just want to make just two points in terms of due process.

Senator COHEN. I wanted to ask you a question. Then—I won't cut you off. For my own purposes, would you evaluate the original language found in the regulations, how we evaluate symptoms, including pain, and the language contained in the regulation which was stricken in the so-called "POMS," which you called to my attention, the language:

> If you have a physical or mental impairment, you may have symptoms like pain, shortness of breath, weakness, or nervousness. We consider all of your symptoms, including pain, and the extent to which signs and laboratory findings confirm these symptoms."

Compare that language and the general intent with the section in the Pickle bill which says that "Individuals' statements as to pain and other symptoms shall not alone be conclusive evidence of disability." As defined in this section, there must be medical signs and findings established by medically acceptable laboratory diagnostic techniques, et cetera.

Is there a significant difference?

Mr. STEIN. I don't think so. I think the Pickle bill's language, is inadequate. It's nice to have something explicit in the statute, since the agency has ignored court decisions for years, but I read that particular Pickle language to the head of a pain clinic in a Philadelphia hospital, and she felt that a majority of the cases that she treats regularly for pain would not meet that kind of objective clinical "medical signs and findings" test that is in the H.R. 6181 bill because of the very subjective nature of pain.

Senator COHEN. Let me read the original regs that included:

> We will never find that you are disabled based on your symptoms, including pain, unless medical signs and findings show that there is a medical condition that could be reasonably expected to produce those symptoms."

That was stricken by the so-called POMS.

How does that differ from what the Pickle bill says?

Mr. STEIN. I think the Pickle language is similar. I don't have it in front of me. Neither the POMS nor the Pickle language comports with Federal court case law, which has established that pain by itself can be disabling. What we would like to see is an amendment that comports with Federal court decisions on pain, which not only encompasses the clinical findings but also recognizes that pain itself, at a subjective level, can be disabling.

I know that I've gone long. I would just like to make a few additional comments on benefits continuing pending the hearings.

One of the most important procedural changes in S. 2086 is to continue the benefits until the hearing decision. We feel that is the most important due process protection for the innocent victims of the CDI reviews.

Currently, those on SSI disability have this due process right. There has been no reported abuse of this right. H.R. 6181 goes part of the way there, but does not go where it should, which is continuing the benefits for those people who appeal, until the hearing decision.

The two other denials of due process are the POMS—and we've already heard about how the social security rulings will be really an attempt to legitimize these POMS without any Federal Register and public comment requirements. We think that this should be immediately stopped.

We also think that the quality assurance and review process has shown just another aspect of the "star chamber" justice that's provided by social security.

Without going into details of the case, we set forward a gentleman, Joseph Borell who has cancer of the bladder. This case shows how a quality review office, out of the SSA's Mount Olympus, reversed and terminated a clearly disabled person, without giving the treating physician's evidence any weight.

Just in conclusion, let me say that the lawlessness and inhumanity of a once benevolent agency must be drawn to an immediate close. We trust that this committee can accomplish this speedily.

Thank you for the invitation and opportunity to give this testimony.

Senator LEVIN [presiding]. I am going to ask just one question. I will try to limit it to that, because of the hour. There may be additional questions, and the record will be kept open for an additional 30 days, for questions for any of our witnesses.

My question is philosophical in intent. The agency has taken the position, I believe, that it should judge old cases under new rules. If there is a tightening of the rules, that it is fair not only to require people to prove their case all over again, but to prove it all over again under stricter rules.

Would you agree with that, Ms. Grover?

Ms. GROVER. I think that's a fair statement of what's happening, on a philosophical level.

My claimants are no more able to perform substantial gainful activity than they were 5, 10, or 12 years ago.

Senator LEVIN. How do you handle the logic that results when you have two people, both of whom have the same disability, one of whom will be eligible and one of whom will be ineligible? The one who is ineligible is the one who perhaps was found to be eligible a few years ago.

Does that create a problem for you?

Ms. GROVER. Yes. It does. I think the problem for me stems from where these people are found disabled. Most of my claimants have been through at least one prior hearing, because they have disabilities that might not neatly fit within the POMS.

Senator **Levin**. I'm talking about two people who have exactly the same disability. Objectively, subjectively, they have the same disability, but the standards have changed as to what constitutes a disability.

Now, do you find a problem with saying that a person who is judged disabled under old standards should continue to be disabled and qualify, while a person who just comes along now, under the new standards, should not be?

Ms. **Grover**. I have a real problem with that. Yes.

Senator **Levin**. It's something we've been struggling with around here, and obviously we haven't solved. The GAO says that the Congress ought to act in this area; and Congress has.

Ms. **Grover**. I think one way to solve that is the presumption of continuing disability. And I think that presumption is only beneficial if the disability is defined, as it was in the additional entitlement.

Senator **Levin**. So that old disability cases should be judged according to the old standards, and new ones according to the new standards, even though it means that two people with the same disability would be treated differently?

Ms. **Grover**. I guess I haven't seen two people with the same exact disability going through the entire appeal process, and necessarily coming out with a different standard.

The administrative law judges, at this point, because they look at the total person, and they judge the inability to do substantial gainful activity, seem to be the safe route in that system.

Mr. **Stein**. Senator, I would suggest that current standards are completely illegitimate. The act has never been amended to adopt the new standards; the regulations have not been changed. And what we have are simply unpublished instructions going out to State agencies, which makes the entire process of CDIs and initial application decision illegitimate.

Until social security comes to Congress and says, "We don't like the standards, change the act," or, we're going to go through a rulemaking process, to create an opportunity for public comments on them—then their entire process, both for applicants and for continuing reviews, is illegitimate.

Senator **Levin**. I agree with that.

My question remains: Assuming that process is followed, and we have stricter standards, do we apply, on review, the stricter standards or the older standards?

Mr. **Stein**. I think to be equitable the answer is: Apply the older standards.

Senator **Levin**. To the old cases, and new standards to the new ones, assuming that the new standards are properly achieved?

Mr. **Stein**. Yes. I think there's an equitable reliance interest there, although it obviously will produce some inequitable results. And I'm not too happy with that inequity. But certainly, people who have been on disability for years should have the presumption of continuing disability. They should have the protections of the substantial medical improvement test, the burden on the Secretary to prove substantial medical improvement. I think that will make it somewhat more equitable, too.

Senator **Levin**. I want to thank you both. We are sorry, to all our witnesses, for the delays. But I think we've gotten submissions which have taken some time and will be worth it, both to you and to us. Again, our thanks to you.

[The prepared statements of Ms. Grover and Mr. Stein, with attachments, follow:]

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May 21, 1982

United States Senate
Committee on Governmental Affairs
Subcommittee on Oversight of Government Management
Washington, D.C. 20510

Re: Written Testimony to Senate Subcommittee on Oversight of Government Management

Dear Senators:

At this time I would like to briefly introduce myself to you. I am an attorney practicing in Portland, Maine. For nine years I have worked with the disabled population of the State of Maine as a rehabilitation counselor, as a legal services intern and as a public and private attorney. The last three years have been spent representing claimants before the Social Security Administration. For the first two years of this period I was the Director of the Handicapped Rights Project, a small university-based legal services project for handicapped individuals. At that time I provided direct representation to claimants and supervised my staff in their representation of claimants. Last year I began a private practice almost entirely limited to representation of Social Security claimants. In the last eight to nine months there has been a significant increase in my case load because of the wholesale termination of Social Security disability insurance benefits as well as SSI benefits based on disability for people who both need and deserve them. At the present time these termination cases comprise almost 50% of my case load.

The major problem is the way in which many wholesale reviews are being conducted. The present review system does not comply with due process requirements in that we do not have an adequate review of the determinative issues. Specifically, although the law speaks of disability in terms of a total inability to do substantial gainful activity, the initial two levels of review done by the state agency under contract from the Social Security Administration, are done only on the basis of whether or not an individual's physical or mental condition meets the criteria of a particular impairment as listed within the regulations. There is no consideration given to medical opinions or other evidence which indicates a continuing disability if that evidence does not directly bring an individual within a specific listed impairment. This is true despite the fact that the Social Security regulations demand consideration of a broad range of vocational and medical aspects of a claim. It is only when an individual's case reaches the administrative law judge that it is fully and adequately reviewed in accordance with the Social Security regulations. Thus, two sets of rules are being used, resulting in an awesome amount of wasted time and effort.

My experience has shown that there are three major disability groups which are hit the hardest by these reviews, the first consisting of people with psychiatric disabilities. In Maine there seems to be an inability to make accurate decisions regarding psychiatric disabilities. This may be the result of lack of ability of the parts of the state examiners or may be due to a lack of medical persons qualified to deal with psychiatric disabilities.

In a too common example, one of my clients was denied continuing disability at the state level, but when his case was forwarded to the Office of Hearings and Appeals a decision was rendered on the record. The medical evidence from the treating psychiatrist was sufficiently clear that a hearing was totally unnecessary. The only way that such a decision can be rendered is if the medical evidence alone is competent to determine that an individual meets or equals a listed impairment. This is exactly the decision that should have been made at the prior two levels of decision making by the state agency. It simply wasn't done and required an administrative law judge to review the record and make that decision. The fact that the state agency was not capable of rendering a decision on the basis of that same evidence indicates an inability to make the right decision even where the facts and the law are absolutely clear.

In another case which involved an initial determination rather than a review, the same result was reached. There, when the record was forwarded after being denied twice by the state agency, a decision was rendered by a different administrative law judge on the evidence and the record alone as that evidence clearly would not allow a different result to be rendered.

I would again remind you that if there is any conflicting or inconsistent medical testimony a hearing must be held to resolve those issues through the testimony of the claimant and any witnesses as well as, in most instances, through medical opinion offered by a medical advisor present at the hearing. The fact that neither of these were necessary in the two above cases indicates that the record was complete, and that the claimant was clearly disabled, yet the state agency was simply unable to perform their duties properly.

In two other psychiatric cases which did go to hearing before new judges, the only current medical in the file was from physicians who had examined the claimants at the request of the Social Security Administration and submitted reports. In both cases, the report from the consultive exam performed at Social Security's behest, was that the claimant was totally disabled and unable to perform substantial gainful activity. Despite that overwhelming evidence these claimants were denied continuing benefits and forced to go through the remainder of the administrative procedure, which included a hearing before an administrative law judge.

To inflict this senseless pain on recipients of Social Security benefits is simply inexcusable. The fault lies with the system of review which employes ill trained people to apply rules much narrower and more stringent than any ever contemplated by Congress. This system insures that claimants are terminated every time they are reviewed regardless of the medical evidence in the file and regardless of how that evidence has been previously interpreted in the decisions of administrative law judges.

Another psychiatric case involved a 62 year old gentleman who had been receiving SSI benefits on the basis of disability for approximately eight years. It was a year and a half prior to his hearing that he had acutally applied for disability insurance benefits and the review process was never completed on that initial application and the determination was only rendered when he was reviewed on the SSI status and the issues were combined at hearing.

Included in that claimant's medical evidence was the fact that he had spent 29 years of his life at the State Institution for the Retarded. This man had been institutionalized from age 11 until age 40. He had held no employment since approximately 1970 and yet under the state agency's interpretation he had regained the ability to function sometime in 1980 and was no longer eligible for SSI benefits or disability insurance benefits.

A very cursory hearing on the issues resulted in the claimant's benefits being reinstated. In a case such as this gentleman's the evidence was clear. But he was still forced to go through the entire administrative procedure.

Another gentleman with a psychiatric disability has again been receiving disability insurance benefits for approximately ten years during which time he has received continued treatment from the Veteran's Administration for his disability including massive doses of medication. Typically, the only medical evidence in this claimant's file indicated that this man is totally and permanently disabled, at no time enjoyed an improvement in his functional abilities,and was not able to do substantial gainful activity. Yet he is been denied continuing benefits.

Another group of clients which seem unable to achieve success at the initial two levels of review are those suffering from back conditions. The state agency looks at a back condition only in terms of whether or not it meets or equals a specific listed impairment. As with any list, the List of Impairments is limited in its ability to include all possible variations, and is of limited use.

What seems to be a problem in the area of back disabilities is that,as you might imagine, many of these disabilities are not easily diagnosed. The state of medical art in terms of diagnosing and treating back conditions is somewhat limited. It simply is not possible in all instances to obtain clinical and laboratory findings to support a specific diagnosis. Often times chronic intractablepain is not evident in X-ray or laboratory evidence.

The state agency has specifically informed me that they do not accept pain as a disabling condition because it is not contained within the list of impairments. A person with a back injury must have one of those specific injuries listed within the listed impairments in order to be found eligible for benefits.

One particularly glaring case is that of a thiry-six year old gentleman who has had three disc operations on his back, none of which has been successful. At the present time the only medical evidence in this claimant's file is from the treating orthopedic surgeon and a nuerosurgeon who performed a consultive exam. Both physicians find the claimant to be totally disabled with a very poor prognosis and neither recommends any further treatment. Based solely on this medical evidence the claimant has been denied continuing benefits.

The third major disability group which seems to suffer the most under the present review system are those people who have multiple impairments. As you might imagine, the listed impairments basically do not deal with persons who have multiple severe problems none of which meet a specifc listing but, when taken together, cause the person to be totally disabled. These people simply cannot be fairly adjudicated under the listed impairments and yet, at the first two levels of review that is the only criteria applied to determine their degree of impairment.

These are people who will never fit within the listed impairments under the strict construction given by the state agency and so will always be terminated from benefits when their claims are reviewed. In most instances benefits will be reinstated, but only after pursuing the full administrative procedure. This process means an average of 10 to 18 months without benefits.

One sriking example is that of a middle aged woman who suffers from residuals of a stroke as well as a heart condition and circulatory problems. Again, the only evidence in the file was from the claimant's treating physician who stated that the claimant remained totally disabled and that her condition had deteriorated during the period of review. This claimant was denied continuing benefits until she appeared at hearing before an Administrative Law Judge and the state agency's decision was reversed. She was without benefits for a period of twenty months during which time she lost her home and car because an inability to remain current on payments.

This woman's disabling condition stems not from one impairment but rather from several severe impairments, no one of which meets the criteria in the listed impairments. Because she is disabled by many impairments rather than oneshe will never be found disabled at the initial two stages of review.

It has been my experience that many claimants who suffer from multiple disabilities are less able to perform substantial gainful activity than those claimants who have one severe impairment which meets the criteria of the listed impairments. The person with multiple impairments is foreclosed from many avenues of accommodation which might be available to persons who have only one impairment.

As you might imagine, persons with a severe mobility problem can often compensate by utilizing sensory/and mental skills in the job market. The individual who has a moderately severe back condition along with mild mental retardationand a hearing deficit has far less options, yet is deemed not disabled because no one condition meets the criteria of a listed impairment. The number of these people is significant and they are being penalized by a review system which fails to adequately examine the issue of disability. This constitutes a violation of due process as these claimants are being denied without an adequate opportunity to be heard. The opportunity to present evidence is a hollow gesture if that evidence is not going to be reviewed in an appropriate manner.

I consider the overturn rate on cessation cases to be high. At the present time I cannot furnish you with what are statistically significant figures simply because the review process is so new. The majority of my cases have not yet been finally adjudicated. Presently I have eighteen clients who have had their benefits ceased. Seven claims have been adjudicated, five at the hearing level. Four hearings resulted in a reinstatement of benefits and one case has been continued for the development of furhter medical evidence. Benefits were granted to two claimants on the medical evidence in their files without a hearing. Although it is impossible to ever guarantee outcomes at the hearing I think it is fair to estimate that the majority of these claimants will have their benefits reinstated.

In addition to the above substantive problems ther are many procedural problems that hinder the appeal process. The average lenght of time necessary to process an appeal and reinstate benefits is ten to eighteen months.

The state agency is expeditious in rendering both initial and reconsideration decisions. Expedited handling seems to be given priority over accuracy and quality.

In one particular case a claimant was to be examined by the treating surgeon to determine if further treatment would be beneficial. This appointment was scheduled for one week after the expiration of the imposed 10 day filing limit for new medical evidence. Although this evidence would be of infinite value in ascertaining the level of the claimant's disability, the state agent refused an extension on the basis that he was without authority to grant such an extension. The state agency does in fact have the autority to grant such extensions. It required the intervention of a local congressional office to obtain the necessary time extension. The state agency had been prepared to render a decision as to whether this person would continue to receive benefits without the necessary medical documentation in order to render a speedy decsion.

In another case the state agency asked a claimant to appear for a consultive examination in a town approximately 45 miles from his Portland residence. Although the claimant does not own an automobile and there is no available public transportation, the state agency maintained that this was not an unreasonable request as a local exam could not be scheduled without a delay of approximately two months. The claimant should have the authority to delay his own case if it is in his or her own best interest.

In an instance like this when a claimant's case is to be adjudicated on this new medical evidence and they are offered only anoption of walking forty to fifty miles orhaving a decision made without the benefit of new medical evidence, it would appear to be an unreasonable standard. The only purpose served by these unreasonable demands is the state agency's goal of rendering speedy if inaccurate decisions.

One procedural problem which I consider to be of great consequence is the inability to obtain copies of medical records from the claimants' files. It is almost impossible to obtain these records prior to filing a request for hearing. The local District Office in Portland, Maine has a policy which denies the forwarding of any client records. The rationale being insufficient support staff. The will allow attorneys to come to their office and review files and then make their own copies. Although I am sympathetic to their staff needs this policy makes it virtually impossible for a sole practioner to obtain records. Policies such as these severely limit a claimant's ability to retain counseland jeopardizes his or her right to representation.

The problem of obtaining records takes on added significance when viewed in light of the House Bill HR 6181 submitted by Congressman Pickle. That Bill would provide that no additional evidence could be admitted subsequent to a reconsideration decision. As it is almost impossible to obtain copies of the evidence prior to a recosideration decision, it would make it almost essential to request a hearing in order to obtain a copy of the file. If further evidence were indicated it would be necessary to request a remand to the reconsideration stage. After denial on reconsideration, a second hearing request would be necessary.

In my three years experience as a claimant's representative I have found the reconsideration review to be of no utility. I have only known of two cases in that period of time where an initial decision was reversed on reconsideration.

The proposal assumes that the problems at the reconsideration stage are due to a lack of evidence which is then made available to the Administrative Law Judges. As I have indicated above the problem at the reconsideration stage is the scope of the review and the standard applied rather than the amount or quality of the medical evidence reviewed.

To terminate benefits without current medical evidence is simply unconscionable. However, to simply state that benefits continue only until such time as current medical evidence was available to substantiate the initial decision would be of limited value to my clients. The cases which I have detailed above involve current medical which is incontroverted and still decisions have been rendered denying benefits. It is the treatment of medical evidence rather than the existence of medical evidence that gives rise to the problems in Maine. To properly address the problem requires examination of the substance and scope of the review rather than limiting the issue to the acquistion of medical evidence.

The underlying problem in this system is the criteria under which the state agency reviews the medical evidence. If his criteria cannot be changed so that the state agency has the flexibility and the requisite training and ability to review the medical evidence in light of all the criteria and not just the listed impairments, then I would suggest that the initial two levels of decisions be eliminated. I feel that neither of these initial two decisions comports with due process as the appropriate determinative issues are not addressed through the the review.

As you might imagine I would not suggest that the standards presently used by the state agency be imposed upon the Office of Hearings and Appeals. As I have stated at length, the limitations inherent in the use of the listed impairments as an exclusive measure of disabilityallows for many totally disabled persons to be found not disabled. The list of impairments does not take into consideration those persons who have multiple disabilities no one of which meets the criteria of a specific listing but, which when taken together cause the person to be totally disabled. Without the flexibility to look at all the criteria for determining disability we simply eliminate a very large number of disabled persons from receiving the disability insurance benefits which they may have paid into for twenty or thirty years.

I don't believe that we as a society would choose to deny disability benefits to persons who are totally disabled because their disability is not limited to one specific part of their body but rather is the product of many disabling conditions. To draw that type of distinction for administrative convenience is without justification. I believe that as a society we have a responsibilityto provide benefits to persons no longer able to perform substantial gainful activity. An integral part of that responsibility is providing an adequate and competent review of the individual's disabling condition or conditions.

I would srongly recommend that the Social Security Act, as it relates to the termination of benefits, be amended to include a presumption of continuing disability, placing the burden of proof on the Administration to show that the disability no longerexists at the same level of severity. The amendment should further clarify that such disability be defined by the prior determination to grant benefits. That is, if an Administration Law Judge, in a prior decision, has determined that a claimant's multiple disabilities are the basis for entitlement, those same disabilities must be presumed totally disabling. It would then be the Administration's burden to show that all or some of these conditions had improved significantly and hence resulted in a non-disabling condition. It is important to spellout that claimants will not be subjected to review under the criteria of the listed impairments when, in a prior decision, they have been found totally disabled under additional criteria.

If the standard of review is not changed many persons will be subjected to long and difficult appeals. The mandatory review process should only continue if claimants are offered a competent review of all the pertinent data and not merely a partial review.

In summary, we have a review process which does not adequately deal with the issue of disability. The process is slow and cumbersome, requiring legal representation and great expense, both to the Administration and the claimant. Because these claimants are, for the most part, without alternative income we are causing extreme hardship and suffering to those least able to protect and defend themselves. We have singled out the weakest and the poorest in our society and imposed on them an almost insurmountable financial mental hardship.

Although we are discussing these issues only in light of the review process I would like to remind you that these same problems exist for those persons making an initial application for benefits.We are talking about a significant number of people who are truly suffering because of the administration of the eligibility policy both in initial decisions and in the review process.

Thank you very much for this opportunity to present my thoughts in this matter. I feel very strongly about these issues because I am daily faced with clients whose lives are devestated by the mechanical decisions of the Social Security Administration.

Respectfully submitted,

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# TESTIMONY

OF

JONATHAN M. STEIN, ESQ.

OF

COMMUNITY LEGAL SERVICES, INC.

PHILADELPHIA, PA.

ON BEHALF OF

ACTION ALLIANCE OF SENIOR CITIZENS
OF GREATER PHILADELPHIA

AND

PENNA. COALITION OF CITIZENS
WITH DISABILITIES

AND

DISABLED IN ACTION
OF PENNSYLVANIA

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT
OF GOVERNMENT MANAGEMENT
OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

MAY 25, 1982

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Senators Cohen and Levin and Members of the Subcommittee:

I am Jonathan Stein, Chief of Special Projects at Community Legal Services in Philadelphia where I have practiced law for low-income and disabled clients continuously since 1968. On behalf of thousands of our disabled clients who are falling victim to the callous and almost punitive treatment coming from the Social Security Administration and state Disability Determination agencies, we wish to thank the Subcommittee for taking this initiative and holding this most important hearing.

The arbitrary terminations since March, 1981 of over 175,000 on Social Security and SSI disability has become a national scandal and demands the most prompt of legislative remedies to reign in a lawless and heartless federal agency.

In my current position I represent many disability clients individually and in class action litigation recently filed in Pennsylvania representing over 250,000 SSDI and SSI beneficiries. Kuehner v. Schweiker, C.A. No. 82-1839 (E.D. Pa. 1982)(Weiner, J.). Our legal services program represents or interviews hundreds of disability claimants, the great majority being victim of the pernicious continuing disability investigations (CDI's) underway in unprecedented numbers now. I am also in almost daily contact with advocates across the country around this issue and my testimony reflects the observations of my colleagues in my program and in legal services offices around the country.

Contrary to the line which Social Security Commissioner Svahn is offering Congress, there is a clear pattern of abuse and errors being made. We would conservatively estimate that 90 to 95% of all CDI reviews leading to cessation are clearly erroneous decisions which no one on this Committee would ever sanction. Moreover, the 5-10% of the others are at best borderline cases which nevertheless are not being fairly decided.

The prime causes of this scandal are the unprecedented combining of three factors:

First, is the impossible volume of cases being pressed upon state DD agencies, currently at 30,000 new reviews a month, to increase next year;

Second, are long-standing systemic weaknesses and failings in the federal and state disability processes, ignored for years by Congress and SSA, and now suddenly painfully visible as hundreds of thousands fall victim to these long ignored administrative failings; and

Third, is an undeniable effort by the current SSA administrators to save money on the backs of the disabled by changing standards of determining disability, accomplished quite secretly without Congressional sanction nor with notice and comment rights offered to the public to scrutinize what in essence has been agency sub rosa amendment of the Social Security Act and properly promulgated regulations.

## High Volume Reviews and Systemic Failings Combine to Forge a Prescription for Disaster

The mandate of the 1980 Social Security Act Amendments to review all cases of permanent and non-permanent disabilities in a relatively short period of time, in addition to the hundreds of thousands of regular application determinations ordinarily required is simply an impossible task for any state DD agency.

The entire justification for this CDI requirement for all cases has erroneously been called a "G.A.O. study" by Commissioner Svahn. In reality it was a Social Security study which cannot be assumed to be objective and independent of bias; moreover, the reports' conclusion on ineligibility of a minority of beneficiaries never tested the numbers of supposed ineligibles against whether the initial decisions concluding they were ineligible would be upheld upon appeal. With reversals on appeal before ALJ's of 60% or more and with over half the rest succeeding in federal court, any initial findings by anyone in SSA must be highly suspect.

We urge Congress to reconsider and repeal these mandatory reviews of all cases and review a much smaller number where substantial medical improvement is both probable and can be proven to justify cessation. Specifically, the high volume of reviews has had the following effects:

1. Cursory review of the evidence. The state adjudication process can only be described as arbitrary and completely failing in due process. A recently disclosed

report of the Pa. Office of Vocational Rehabilitation, for example, admitted that its DD bureau engaged in a "dehumanizing" and "frenzied" adjudication process, where the bureau could not possibly meet the demands of the 1980 Amendments. See Pa. Office of Vocational Rehabilitation, Task Force Report on Bureau of Disability Determination (Feb. 1982), filed with Subcommittee staff, and "Task Force" Disability Agency 'Not Responsive'", Philadelphia Inquirer, p. 4B (May 21, 1982), attached as Exhibit 'A'. Although the adjudicator[25] theoretically has all the prior information available, in practice the adjudicator ignores all the evidence but the most recent consultative examination, ("CE's"), the one-shot medical exam given by a doctor who has never seen the beneficiary before and who rarely has any medical history available to him or her.

75% of the 540,000 CDI's will utilize Consultative Examinations ("CE's") as will 40% of initial determination cases, according to SSA Assoc. Comm'r Sandy Crank (Testimony of Sept. 18, 1981 before House Social Security and Oversight Subcommittees).

Consultative examinations have been made mandatory as a matter of SSA policy, even if there is enough evidence in the file to make a decision. See Program Operation Manual System §DI 2810.4. Despite Congressional hearings last Fall, SSA has imposed no controls over the use of so-called "high volume consultative examiners"; SSA refuses to provide CE doctors with complete, prior medical histories; and appears blind to a pattern throughout the country of the most abbreviated and shoddy examinations, which in Pennsylvania, at a maximum fee of $35, produce low quality evidence yet determinative of a person's entire entitlement.

2. Ignoring of treating physician evidence. In practice treating physicians are totally excluded from the process. The high volume of cases causes adjudicators to cut corners and not seek such evidence. Thus Pa. adjudicators told a client, Robert Astrove, who is 60 years old and a World War II veteran, whose multiple disabilities include severe arthritis, angina, high blood pressure, diabetes, and a psychiatric nervous condition, that they would not even write to his two treating VA hospital doctors, a neuropsychiatrist and an orthopedist because as a matter of policy they could not wait for VA to respond because then they would not meet their processing time goals.

In addition, evidence more than 3 months old is not considered "current" in Pennsylvania and is deemed irrelevant, something which would shock any professional physician.

SSA always falls back on the lame excuse that the claimant must prove his disability, yet their form Cessation 1 notice gives the beneficiary as their "due process" but 10 days to obtain additional medical evidence making it virtually impossible for the beneficiary to obtain additional treating medical source evidence. Moreover, the very physical and mental disabilities of the claimant plus his dependence on over-worked Medicare and Medicaid doctors make it grievously unjust for SSA to put the burdens of proving disability this way upon the claimant during the initial review processes.

Current SSA policy in the POMS does not even mandate that treating physician evidence be fully developed and complete in the file before a CDI cessation is ordered. See SSA, Program Operation Manual System, SDI 2862(B) (July 1979), attached as Exhibit 'B'.

When treating medical sources are sought, the state DD agency almost never informs them of the type of medical information required, nor are they given copies of the Listing of Impairments. Thus initial reports from treating doctors often lack the required specificity because SSA and the DD agency hide the ball from them. When caring and conscientious doctors summarily conclude what is often obvious even to a layman, that a person is totally disabled, the state DD agency as a matter of SSA policy ignores the report as conclusory and fails to follow-up with requests for more detail. See 20 C.F.R. §404.1527.

Finally, SSA and DD agencies fail to afford to treating physician reports the binding effect and great weight our federal courts have uniformly held is required in relation to the one time consultative exam. See, e.g., Bastien v. Califano, 572 F.2d 908,912 (2d Cir. 1978); Hephner v. Mathews, 574 F.2d 359,362 (6th Cir. 1978); Allen v. Weinberger, 552 F.2d 781,786 (7th Cir. 1977); Rossi v. Califano, 602 F.2d 55,58 (3d Cir. 1979).

Because the HHS Secretary and SSA Commissioner have ignored repeated federal court decisions on the use and weight of treating medical source evidence and the clear value this evidence possesses, coming from professional experts who are most familiar with the person's medical conditions, we urge Congress to amend the Act to require full development of treating medical evidence for the immediate past year, affording it the weight it requires. We suggest an amendment to Sec. 223(d)(5) by adding:

> (8) In any case where the Secretary is conducting a continuing disability review of any individual already receiving disability benefits, the Secretary shall not make any decision terminating or suspending benefits without first obtaining complete and sufficient medical reports from all medical personnel treating the individual within 12 months of the time of review, and without the Secretary having given to these reports probative weight greater than that given to any consulting examination administered.

3. Medical Improvement Deemed Unnecessary to Prove. Up until 1976, SSA had a common sense and reasonable burden in CDI cases to show that a beneficiary had medically improved as a prerequisite to a cessation decision. This past regulatory policy, 20 C.F.R. §404.1539(a), 416.939(a)(1979), had found repeated confirmation in legislative history to various amendments to the Social Security Act which show that Congress assumed a cessation was appropriate when the disability "may have ceased," Sec. 225 of the Act, 42 U.S.C. §425, only where there existed an improved condition. *See, e.g.*, S. Rep. No. 96-408, 96th Cong., 1st Sess. 4 for history of 1980 Disability Insurance Amendments, Pub. L. No. 96-265, §301(a), 94 Stat. 449 ("not entitled to DI and SSI benefits after he has medically recovered"); S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in (1965) U.S. Code, Cong., & Adm. News 1943, 2044 ("terminate entitlement to disability benefit in cases of recovery based on such evidence"); S. Rep. No. 1856, 86th Cong. 2d Sess. reprinted in (1960) U.S. Code, Cong. & Adm. News 3608,3703, for history to 1960 Social Security Amendments, Pub. L. No. 86-778, §403(a), 74 Stat. 969

(benefits end where "his physical or mental impairment improves to a point whereby reason of such improvement he is able to engage in substantial gainful activity").

In a typical, secretive move, SSA dropped its medical improvement policy in July 1976 belatedly getting around to announce its omission in 1980, see 45 Fed. Reg. 55566 (1980). Thus SSA set the stage to treat every single disabled beneficiary up for CDI review as merely an applicant applying for the first time -- ignoring all prior disability determinations and past medical history. Not surprisingly, then, whereas in 1975 only 16% of CDI's resulted in cessations, by 1978 the rate had grown to 50%. See Subcommittee Survey of State Disability Agencies: Adjudicative Climate, p.17 (Feb. 1, 1979), U.S. House Committee on Ways & Means, Subcommittee on Social Security, 96th Cong., 1st Sess., WMCP: 96-5.

Current SSA uniform policy establishes that "it is not necessary to show that the individual's medical condition has "improved" since the prior determination." Social Security Rulings (SSR) 81-6 (Jan. 1981) and Memorandum of Louis B. Hays, SSA Assoc. Comm'r, OHA, of Feb. 23, 1982, directing all Administrative Law Judges to ignore a Court of Appeals decision, Finnegan v. Mathews, requiring a showing of medical improvement before cessation. Attached as Exhibits 'C' and 'D' respectively.

SSA's continuing refusal to show substantial medical improvement before cessation perhaps best shows how they wish to push people off disability via assembly line processes which do not even make the most basic and sensible of inquiries: has the beneficiary improved for the better since SSA and the DD agency themselves found him to be virtually totally disabled. Mass volume reviews and the desire to save money have made SSA more insistent in defending its "we don't care if there's no medical improvement" policy. Yet our federal courts around the country have begun to demand that SSA fulfill the intent of Congress by requiring a prior showing of medical improvement in cases coming up for judicial review, See, e.g., Patti v. Schweiker, 669 F.2d 582 (9th Cir. 1982); Finnegan v. Mathews, 641 F.2d 1340 (9th Cir. 1981); Miranda v. Sec'y of HEW, 514 F.2d 996 (1st Cir. 1975); Magee v. Califano, 494 F. Supp. 162 (W.D.N.Y. 1980); Shaw v. Schweiker, ____ F. Supp. ____ (E.D. Pa. Feb. 4, 1982). Typical of SSA's posture, the Administration has ignored all these decisions requiring legal services attorneys to bring affirmative, law enforcement class actions now underway from our program in Pennsylvania, Kuehner v. Schweiker, C.A. No. 82-1839 (E.D. Pa.), in Vermont, Smith v. Harris, C.A. No. 79-244 (D.Vt.), and in Oregon, Siedlecki v. Schweiker, C.A. No. C82-61R (W.D. Wash.).

Congress should not permit SSA to continue to avoid its responsibility to prove medical improvement before cessation.

We therefore suggest amending section 223(d) to add a new subsection:

> (7) For purposes of this subsection and subsection (a)(1) above, a disability shall have ceased only when the Secretary finds that there has been a substantial medical improvement in the disability or disabilities of the individual or where newly discovered evidence shows that the original disability determination was clearly erroneous.

This is a sensible and fair means to go about reviewing beneficiaries who have already, often more than once, already passed Social Security's most stringent eligibility requirements.

4. Resolving All Doubts Against the Claimant. SSA has told state DD agencies, in effect, to treat beneficiaries as new applicants by only looking at their current medical condition. This plus the high volume of cash has led adjudicators to resolve all doubts against claimants without additional pursuit of information. Adjudicators almost never speak to beneficiaries, and as you know, never see them, to resolve doubts. State information in files is not updated. The message is clear: if there are any doubts or questions, terminate the case, and move on the next pile on the desk.

5. Ignoring of Vocational Factors and Changing the Program into a Medical Listings Program. Unlike the widow's and widower's disability programs, SSDI and SSI programs require evaluation of vocational factors when a beneficiary has an impairment which can't be said to meet or equal one of the Listings of Medical Impairments in the regulations. 20 C.F.R. §416.920(d). Thus SSA and the DD agency must review "residual functional capacity and the physical and mental demands of the work [the person] has done in the past," §416.920(e), including "age, education and past work experience," §416.920(f).

Yet adjudicators, under pressure to turn over large numbers of cases, and we believe under clear messages from SSA in Washington to focus solely on the Medical Listings, regularly ignore vocational factors by solely comparing the recent consultative examination report with the Medical Listings and non-published interpretations of them given exclusively to DD staff, thus never appearing in the Federal Register. DD staff do not interview beneficiaries concerning ability to meet demands of hypothetical jobs, nor do they use vocational experts.

There is a most serious question whether the much touted vocational guidelines "grid", set up to streamline cases, 20 C.F.R. §404.1501 et seq., is ever used by DD staff, as many elderly disabled who would benefit from this "grid" are being regularly terminated without any reference to these regulations.

Ignoring of vocational factors not only subverts this entire legislative program but produces the following callous results. A client, Frank Jennings, whose bone cancer and leg amputation at the hip had placed him on SSDI for 9 years, was reviewed in late 1981. Despite his illiteracy and failing to complete the 2nd grade, prior job experience only as a laborer, continuing treatment for bone cancer, and lack of a usable prosthetic leg, he was informed on February 17, 1982 by the Pa. DD agency: "...you can be expected to adapt to other work." He was then terminated. Attached as Exhibit 'E' is his cessation notice and treating physician medical reports concluding he will be "impaired indefinitely."

That vocational factors and age are totally ignored is evidenced by the cessation of a 58 year old World War II veteran, Raymond Stankiewicz. Suffering from severe cervical spondylosis, degenerative joint disease, arterioschlerosis and digital artery occlusion, his latter condition was so serious that he was hospitalized in February and March 1982 for his surgery. During this period his CDI was underway. He soon was informed by mail, during his post-operative recovery, that he was no longer disabled despite two treating physician specialists corroborating his continuing disabling conditions.

Margaret Douglas, aged 57, had been on SSDI for 8 years before due to uncontrollable diabetes, severe arthritis and chronic, degenerative osteoarthrosis of the cervical spine. The state DD's own doctor, a Martin Blake, confirmed these multiple impairments and concluded she had to "restrict her activities generally." Anyone seeing her hobble up her stairs on the CBS National Evening News telecast on Saturday, May 15, 1982, had to be shocked to hear that based supposedly on the Dr. Blake report, ironically supportive of her claim, Mrs. Douglas was informed in September 1981 that she was not disabled and her benefits ceased last November 1981.

6. Ignoring of Non-Exertional, Mental Factors. The most striking victims have been those with non-exertional, mental impairments whose disabilities, one must conclude, are being ignored in a wholesale fashion. Thus such clients of mine as Frank Kuehner, 12 years on SSDI due to a Manic-Depressive Psychosis have been terminated, with Mr. Kuehner being examined for but 10 minutes during a state consultative examination.

Frank Fisher, receiving SSDI since 1972 for chronic schizophrenia was cut off despite strong treating physician evidence confirming his severe psychosis.

Clinton Royal's schizophrenia was similarly ignored in a CDI resulting in a cessation. Since 1979 when he began receiving SSDI because of acute psychotic episodes requiring hospitalization, his condition, marked by hallucinations and convulsions, has worsened and his doctor wants to re-admit him to a mental hospital.

For Ms. M.K., the ultimate irony was that despite her severe depression, rendering her unable to work nor to maintain any personal relationships -- she has said, "the state should build gas chambers for people like me" -- she received her mid-1981 cessation while she was being hospitalized for two months in a Philadelphia psychiatric hospital.

And for Mara Park, a severely disturbed schizophrenic found walking the streets of Philadelphia with no money and no medical care, she lost her disability benefits without ever receiving a notice of the CDI review. No one in SSA or the DD agency ever considered that a personal contact was mandatory with a schizophrenic.

In sum, SSA and DD agencies have virtually amended the law to rule out psychiatric disabilities.

### 7. Ignoring of Pain in Adjudications.

SSA and DD agency bureaucrats have effectively anesthesized their policies, as well as their consciences, from the pain symptoms of the thousands of disabled living with daily, recurrent pain. Regulations still require consideration of pain symptoms, 20 C.F.R. §416.929, as well as do federal courts decisions in every Circuit, too legion to cite, with many holding that pain itself can be found to be a disabling condition. Yet in the last two years, the Evaluation of Pain section of the POMS, §DI 2205 (July 1979) has been eliminated with the cryptic instruction from SSA that "deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed." See Exhibit 'F' attached. We have not seen one case where pain was recognized in whole or in part to award benefits. Thus contrary to promulgated regulations and binding federal caselaw a lawless agency has decreed that pain is irrelevant.

Not only does this illustrate further the callous subversion of Congressional intent in this program, but also the underhanded subversion of the Administrative Procedures Act which requires notice and comment on substantive policy changes made by SSA. Through an internal, secretive change in the POMS, the disability law on pain, as well as in other areas, has become radically changed.

And now to make matters worse, in the name of uniformity of standards, the Administration is embracing H.R. 6181 (formerly H.R. 5700) Section 7 of which would require "uniform standards...applied at all levels of adjudication." Rather than creating "uniformity" in his agency by conforming to federal court decisions and the law of Congress, Commissioner Svahn thus wishes to elevate his internal POMS to the status of law to impose as binding rules on ALJ's and the Appeals Council but without subjecting the POMS to Federal Register publication and APA requirements. This is an affront to fundamental fairness for all those on Social Security and to our system of government by law, not Social Security bureaucrats.

8. Adverse Impact on the Appeals System.

SSA currently is trying to have it two ways concerning appeals: on the one hand they praise the appeals system as correcting the many horror cases published in the media, thus "adequately safeguarding individuals' rights" (Commissioner Svahn's Letter to the N.Y. Times, May 20, 1982), while at the same time scapegoating the Administrative Law Judges for reversing DD agencies 60% of the time or more, and, behind the rhetoric, trying to subvert the ALJ's through administrative and proposed legislative actions. The scapegoating will escalate because as the CDI's continue, if this Committee and Congress allow them to continue, tens of thousands of appeals will be essential above normal appeals to correct the horrible decision making going on at state agencies. Just like the messenger who brought bad news from abroad, the ALJ's signaling the errors made below, will be and are now on the Administration's chopping block. Mass reviews are making appeal problems worse:

a) Delays Will Increase. Currently it takes close to 3 months to get a reconsideration decision, most often a needless rubber stamp of the initial denial or cessation; it is up to 6 months to get an ALJ hearing scheduled; 2-3 months more for a decision; and up to 6-7 months further to get a hearing decision effectuated. Thus delays currently are at least a year before the terminated person gets a hearing, at which 60% of the CDI cessations are being reversed. It takes months more before benefits are re-commenced. This is at a time when this past year there were 175,000 ALJ dispositions. Further delays ensue for Federal Court reviews where an additional 50% and more cases are reversed or remanded.

Increased rates of appeal will greatly worsen the delay problem.

b) Quality of ALJ Decisions Suffering. The increased pressures on ALJ's is decreasing their efficiency and quality of decisionmaking. Few referrals are being made for medical consultative exams and other steps required by our caselaw for ALJ's to look after the claimant's interests to develop a full evidentiary hearing record -- left incomplete by the state DD agency -- are not being pursued. The requirements of the so-called on motion Bellmon reviews of high allowance ALJ's -- but not interestingly high disallowance ones -- mean that ALJ's must write long decisions in clear-cut cases delaying the decision for months without any substantive change in result.

c) Misguided Proposals to Improve the Process. Instead of taking steps to mandate adequate development of the evidence at the state DD level, including face-to-face interviews with claimants by the DD agency, the Administration is embarking on policies to subvert the only independent adjudicators in the system:

(i) The proposal in H.R. 6181 to close the record to new evidence at the reconsideration stage, preventing ALJ's from hearing this evidence, puts impossible burdens on uncounselled claimants to obtain evidence and undermines the ALJ's salutory role to obtain, and if necessary secure the additional evidence;

(ii) An experiment, revived after public outcries killed it two years ago, to have SSA represented at the ALJ hearing will turn the hearing into an adverserial one which neither Congress nor our Courts have sanctioned or permitted;

(iii) Imposing the POMS upon the ALJ's in the name of "uniformity" is a subversive step criticized above;

(iv) Bellmon, on motion reviews solely of high allowance ALJ's is, in effect, a means to harass and intimidate ALJ's who are properly doing their sworn duty. Interestingly, the recent Bellmon report vindicated the high allowance rates of ALJ's by explaining and legitimating their decisionmaking in contrast to the shoddy quality of DD agency decisionmaking. Thus reversals were attributable to the ALJ's ability to examine the claimant in person; additional medical evidence submitted to the ALJ; ALJ adherence to federal court decisions; the fact they are not bound by POMS standards more restrictive than the statute and regulations; and greater representation by claimants at this level. DHSS, SSA "Implementation of Section 304(g) of P.L. 96-265, 'Social Security Disability Amendments of 1980,' Jan. 1982 ("Bellmon Report"), at pp. 16-20, 25-27.

Congress should not allow the continuing, blatant scapegoating of the ALJ's and subversion of the only independent, fair adjudicators in the system.

9. Denials of Due Process and Administrative Fairness by Secret, Internal Decisionmaking Through POMS and "Quality Assurance" Reviews.

Due process of law has been thrust aside amidst these CDI's.

a. Denial of Benefits Pending Hearing Decision. Contrary to what is afforded those on SSI Disability or those on welfare, once a cessation decision is made, the claimant is given the right only to submit additional evidence within 10 days. Benefits then cease until an appeal decision corrects the error. In the interim, great suffering can and does take place.

SSDI does provide claimants with necessities of life, and especially if 60% or more of appeals are reversed claimants should not have to suffer during their appeal. No abuse of the SSI or welfare recipient's appeal rights to aid continued pending a hearing decision has ever been documented. The percentage of SSI disability cessations appeals is not out of proportion to those of SSDI where benefits do not continue pending the appeal.

This denial of due process also denies equal protection of the law to SSDI beneficiaries who unlike the SSI beneficiaries have long work histories of payroll deductions into the Trust Fund. The SSDI beneficiary's income and resources may even be so low as not to exceed SSI eligibility limits yet solely because of a past work history entitling them now to SSDI, they get no aid pending a hearing decision. Equal protection of the law demands they at least receive the SSI benefit level pending their appeal.

The bill sponsored by Senator Howard Metzenbaum and others should be passed as soon as possible to provide necessary due process protections for innocent and severely disabled beneficiaries.

b. *POMS = Star Chamber Justice*. Due process is also denied through the use and revision of the POMS to subvert the Social Security Act and regulations, and the Administrative Procedure Act. We have shown how SSA revised the POMS on pain to undermine Congressional intent and the regulations. Similarly, the POMS are more restrictive and consequently contrary to law in other areas such as standards for determining when alcoholism and drug addiction are disabling, and the listing of what are called "slight impairments," meaning non-severe conditions denied with out considering vocational factors. All these standards have never been subjected to public scrutiny or comment. As an example, "slight impairment" denials went up from 8.3% of initial denials in 1975 to 25% of denials in 1977 due to these new internal, unpublished lists of "slight impairments." Use of this denial code "has been inflated by both conscious and habitual examiner actions to avoid vocational development.... The requirement that detailed vocational history and forms be obtained whenever a vocational biases code is used may have produced a tendency to avoid use of vocational information at the time of the intial disability interview." *Subcommittee Survey of State Disability Agencies: Adjudicative Climate, supra*, at pp. 15-16.

Other examples of abuse of the POMS can be readily provided. POMS must be made to conform to the statute and regulations and the first step is to require their publication and opportunity for comment pursuant to the Administrative Procedure Act.

c. Quality Assurance = More Star Chamber Justice. Under the benign, bureaucratic jargon of Quality Assurance Reviews, SSA has altered and imposed its policies upon state agencies without public scrutiny or knowledge by the disabled victims of these reviews. As inadequate and far removed from the beneficiary as is the DD agency, SSA utilizes a Quality Assurance or Quality Review Feedback Report system where yet a further removed, anonymous bureaucrat, whose role is never revealed to the beneficiary, makes the determinative decision in many cases, and by so doing affects the state DD adjudicator's decisions in other cases.

Joseph Borell, a 52 year old man awarded SSDI in 1978, by an ALJ, because of cancer of the bladder, is an example. Eight months after the ALJ allowance a CDI ended his benefits only to be reinstated on appeal by a second ALJ in mid-1979. Mr. Borell remained disabled due to the weakening of his abdominal wall from the surgery for cancer, with two stomal openings remaining, a large ventral hernia, and by the continuing need to have tubing drain urine from his kidneys. See Exhibit 'F' attached.

Up for yet another CDI and despite two prior ALJ awards for disability and no improvement in his condition, his case was sent to Baltimore for a Quality Review Feedback Report wherein it was concluded from SSA's Mt. Olympus that the "weakened abdominal wall" should nevertheless have permitted him to return to "less strenuous work." The report adds, "accordingly, it can only be concluded that the decisions to allowance decision." See Exhibit 'G' attached. The SSA Request for Case Action to the state DD agency while repeating the form language that the agency is not bound by the reviewer's opinions referred the reader in handwritten instructions to the above quoted Report, and its clear message, adding, "If you determine that a cessation is appropriate, please afford due process per POMS 2868 (sic)." See Exhibit 'H'. Not surprisingly, there was a state DD cessation ordered later which ignored any mention of the weak abdominal wall and hernia, or tubes draining urine 24 hours a day from Mr. Burrell's kidneys. See Exhibit 'I'. The decision did report, "Recent blood tests show that your kidney is functioning normally (sic)." Id.

It is now clear that adjudications are being directed by a totally unaccountable system of "quality" reviews which is kept secret and divorced from any direct sources of information. The claimant cannot rebut or challenge the findings or opinions of the "quality" reviewers as he is not even aware of the determinative role they play. This unjust system must be now stopped before it imposes more gratuitous suffering on beneficiaries.

10. Hardship on Claimants -- SSDI provides necessities of life for most of its recipients. These unfair cessations have led to countless people suffering inadequate diets, loss of homes, and other suffering from material losses. Many states do not have welfare to fall back on and where it is available, as in Pennsylvania, it pays half or less of what is minimally needed for subsistence.

Others suffer losses with no ready measure. James McKeown, a Vietnam veteran, with over 100 operations during the course of his 10 years receiving SSDI, had among his multiple impairments depression for which he was receiving psychotherapy. When he recently received his cessation notice ending benefits to himself, his wife and three small children he had a relapse of his depression, out of anxiety as to how he would be able to care for his family.

Frank Kuehner's loss of SSDI and the Medicare coming with it, resulted in his loss of psychotherapy for his schizophrenia, greatly worsening his mental health.

And what notice, we ask, has Social Security dreamed up for the families of beneficiaries who have committed suicide after cessation of their benefits.

Steps must be immediately taken to stop these cessations and to allow for benefits to continue pending a hearing decision on appeal. Improvements in the development of the evidentiary record early in the process have already been suggested as well as forcing SSA to conform to the Social Security Act, its own published regulations and federal court decisions.

The lawlessness and inhumanity of this once beneficient agency must be drawn to an immediate close. We trust that this Committee can accomplish this speedily. Thank you for the invitation and opportunity to give this testimony.

## Part 1B
## Rulings Based on Program Policy Statements

(Previously Published as PPS-54)

**SSR 81-6**

### TITLES II AND XVI: CONTINUANCE OR CESSATION OF DISABILITY OR BLINDNESS

**PURPOSE:** To state the policy for determining whether disability or blindness under titles II and XVI continues or ceases.

**CITATIONS (AUTHORITY):** Sections 221 and 1631 of the Social Security Act; Regulations No. 4, sections 404.1579, 404.1586 and 404.1594; Regulations No. 16, section 416.994.

**PERTINENT HISTORY:** Under operating guides which have been in effect for approximately 3 years, disability or blindness is found to have ceased when current evidence shows that the individual does not meet the definition of disability or blindness under which his or her claim was allowed; it is not necessary to show that the individual's medical condition has "improved" since the prior determination. However, prior regulations had been interpreted by some to mean that before cessation of disability or blindness could be found, there must have been a positive showing of medical improvement. Such an interpretation precluded a finding of cessation in cases where current evidence showed that the individual was not disabled or blind, but it could not be shown that actual "improvement" had taken place. The regulations have now been revised to clarify this issue.

**POLICY STATEMENT:** Where the evidence obtained at the time of a continuing disability investigation (CDI) establishes that the individual is not currently disabled or blind, a finding of cessation is appropriate. It will not be necessary to determine whether or how much the individual's condition has medically improved since the prior favorable determination.

**EFFECTIVE DATE:** Final regulations covering this policy were effective August 20, 1980, the date of publication in the Federal Register (45 FR 55566).

*Continuance*

If it is found that the individual is working despite a continued severe impairment and such work is within the trial work period, a finding of continuance should be made. In no instance should the work by itself be considered a basis for cessation until the expiration of the trial work period (see DI 2825). Upon expiration of the trial work period, the work should be evaluated by the DO.

When preparing a continuance determination in a case where the individual has been working less than 9 months, if further and substantial improvement is anticipated (DI 2500), the DDS should indicate the appropriate date for a subsequent medical reexamination diary. The diary should be scheduled for the anticipated 8th month of work, at which time an investigation of both the capacity for SGA and work activity may be conducted simultaneously. If cessation is justified on the basis of substantial gainful activity, medical development would be unnecessary. However, if at the expiration of the anticipated 9th month of work it is found that the individual did not, in fact, work in all 9 months or the work does not constitute SGA, the case will still be investigated from a current disability standpoint.

### *F. Cessation*

Where the DDS obtains medical evidence which indicates a cessation is in order, the DDS should find cessation in the month established by the medical evidence, irrespective of whether this coincides with the month of return to work. Retroactive cessation to the month work began should not be found unless the facts (medical and work) convincingly demonstrate the propriety of such action (see DI 2864). For example, if the individual was still severely impaired at the time work resumed but the individual medically recovered by the time of a consultative examination, the month of cessation would be the month of the consultative examination rather than the month of work resumption.

## 2861. Individual Conceded Regained Ability to Work in a Medically Diaried Case—No Return to Work

A cessation may be found when a properly established medical reexamination diary matures and the individual has not returned to work if the individual believes he or she is able to work and the treating physician has released the individual for work activity without restrictions. This situation would usually become apparent through the individual's responses on the SSA-454a. A report of telephone contact with the physician satisfies the folder documentation requirements provided the physician's responses do not conflict with those of the individual. Disability will be found to have ceased in the month the individual was released to return to work, regardless of the date the report was given.

## 2862. Development of Medical Evidence—General

Where return to work does not provide a basis for cessation based on SGA after a TWP (DI 2832), or under the clear-cut concept of medical recovery (DI 2860 C.), evidence from medical sources describing the individual's current medical condition will be controlling in arriving at a decision.

The development process and evidentiary requirements that apply in determining initial disability also apply in determining whether disability continues, however, the development of medical evidence is basically an updating process.

The relevant medical evidence for determining continuing disability should consist of evidence which is sufficiently detailed as to signs, symptoms, and laboratory findings to enable a sound judgment to be made by an independent reviewer as to the individual's current condition. Detail is especially needed when the evidence indicates cessation but the individual alleges inability to return to work due to the impairment or the treating physician has restricted work activity.

The general guides for development of medical evidence will be used in conjunction with special instructions pertaining to conversion cases and Federal Fiscal Liability Cases. (See DI 2851.)

### *A. Vocational Rehabilitation Agency—A Source of Evidence*

When an individual is known to a State Vocational Rehabilitation Agency at the time of the continuing disability investigation, evidence from that agency should be obtained before soliciting or purchasing medical evidence. The evidence available through the vocational rehabilitation agency may be sufficient to permit a sound determination as to whether disability continues without purchasing additional evidence ~~or disrupting vocational rehabilitation activity by a medical work-up~~.

The DDS should contact the vocational rehabilitation agency for a full report about the individual. The information requested should include medical reports relating to the client's current medical status and other data pertinent to a determination involving an issue of medical recovery. Depending on local circumstances, this information may be obtained in the form of a written statement from the rehabilitation records or it may be recorded on a report of contact as a result of a personal or telephone contact.

If data previously obtained from the vocational rehabilitation agency (e.g., in connection with the initial adjudication or ~~an SSA-853~~ vocational rehabilitation closure report) indicated that the case was closed and the individual states that the case has not been reopened, a further contact with vocational rehabilitation need not be made.

#### 1. DOCUMENTATION OF RECOVERY

The evidence received from the vocational rehabilitation agency should be considered with all of the other evidence bearing on the individual's ability to perform substantial gainful work. Current medical evidence, including a consultative examination, if necessary, should generally be obtained when the evidence from vocational rehabilitation is not current or sufficient to determine whether disability continues. In no instance can a clear-cut cessation be made without current medical development in accordance with DI 2860 C. where vocational rehabilitation services are continuing since participation in vocational rehabilitation constitutes "evidence to the contary." Medical recovery may normally be found when current medical evidence establishes a present capacity for engaging in substantial gainful activity. When the medical evidence establishes such capacity, cessation must be found despite the fact that the individual may be an active participant in a State-sponsored vocational rehabilitation program.

*Example:*
Claimant was allowed because of multiple fractures and complications which indicated the disabling condition would meet the 12-month duration requirement. When the medical reexamination diary came due, the CDI disclosed the individual was enrolled in a 2-year bookkeeping course under a State-sponsored VR program. The State agency adjudicator obtained evidence from the VR, which included a statement from the counselor that medically this person is "O.K."; however, one year of schooling remains. The DDS then obtained current medical evidence which clearly established medical recovery. Therefore, a determination of cessation was made.

### 2. DOCUMENTATION OF CONTINUING DISABILITY

There will be instances where the medical and vocational evidence from the vocational rehabilitation agency will be sufficient to permit a finding that disability is in fact continuing. However, a continuance must not be found solely or primarily because the individual is actively participating in vocational rehabilitation. Rather, the evidence must permit a reasonable conclusion that any further medical development would substantiate a continuance.

*Example:*
Claimant was allowed because of a psychiatric impairment. A CDI was made before the reexamination date came due when notice of a return to work was received. The report on the SSA-454 (Report of Continuing Disability Interview) disclosed that the beneficiary was employed part time and was also participating in a State-sponsored VR program. The DDS requested medical and vocational data from the VR agency. The evidence showed that the individual had demonstrated some improvement and was participating in the training program; however, the individual continued to be markedly restricted and further and substantial medical improvement was expected. The medical and vocational evidence received from the VR agency did permit a functional assessment. It was sufficient, together with the report of the continuing disability interview and the evidence previously of record, to support a decision of continuance. The team recommended a medical reexamination in 6 months to coincide with the anticipated expiration of the trial work period at which time an investigation of both the medical improvement issue and work activity may be made simultaneously.

## *B. Securing Evidence of Record*

Evidence of record will generally be obtained where the evidence from the vocational rehabilitation agency is not sufficient to determine whether disability continues. When the individual is not known to a VR agency, the DDS must develop appropriate evidence from medical sources. The responsibility for determining what evidence is needed is placed upon the DDS. If the individual has a current treatment source that source should always be requested to furnish reports of the most recent examination describing the individual's current condition. The medical evidence should contain sufficient signs, symptoms and laboratory findings to permit independent judgment for a sound determination of continuance or cessation.

Occasionally, the evidence from the treating source may not be sufficient to resolve the question of continuing disability. Nonetheless, the presence in file of reports from the individual's medical sources will better insure that no pertinent evidence has been overlooked and thus insure the soundest possible basis for making determinations.

When there is a conflict between the medical evidence of record and the individual's statements, or if the evidence is not sufficiently detailed, a consultative examination may have to be obtained.

NOTE: *In title II cases, the beneficiary must pay for evidence of record. In rare situations, the DDS may pay for some evidence of record (see DI 2013). In title XVI claims, payment may be made to produce evidence of record including medical examinations, when needed.*

## *C. Conflicts Between Individual and the Medical Source*

Ordinarily, where improvement occurs which permits return to work, this fact will have already been communicated by the attending physician to the individual. If, however, when contacted in accordance with DI 2840, the individual states that the physician advised against return to work or the individual feels unable to work because of the impairment, but the medical evidence received from the treating physician indicated that the beneficiary is not disabled, the conflict must be resolved. If the treating physician's position is supported by conclusive objective medical evidence, a consultative examination would not be required. However, if the conflict raises a substantive medical question and the treating physician's position is not fully documented as to signs, symptoms and laboratory findings, it may be desirable to arrange for a consultative examination by an independent medical source before making a determination.

## *D. Consultative Examinations*

When evidence of record concerning the individual's condition is not available, is equivocal, or is not sufficiently detailed in terms of signs, symptoms and laboratory findings to enable a sound independent medical judgment to be made, a consultative examination should be purchased. In selecting a consultative examiner, the attending physician should be given first consideration (see DI 2027). When contacting the attending physician, clearly explain that the reason for requesting a current examination is to obtain sufficient medical evidence in order to evaluate the individual's current condition. Also ex-

Senator LEVIN. Our final panel today is Herbert Brown and Francis O'Byrne.

Mr. Brown is the Administrator of the Disability Determination unit in Nashville. He will provide the Subcommittee with the State agency's viewpoint on CDI.

Judge O'Byrne is an administrative law judge in Chicago, with extensive experience in reviewing disability cases.

We are very happy that you're willing to testify before the subcommittee. Again, let me express the apologies of the chairman, as well as of the rest of the members of the committee, for the length of time that it has taken for us to get to you; but your testimony is very valuable to us, and we appreciate your understanding.

Mr. Brown, if you will proceed.

## TESTIMONY OF HERBERT L. BROWN, ADMINISTRATOR, TENNESSEE DISABILITY DETERMINATION SECTION, NASHVILLE, TENN.; AND JUDGE FRANCIS J. O'BYRNE, SR., ADMINISTRATIVE LAW JUDGE, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, CHICAGO, ILL.; ACCOMPANIED BY JUDGE CHESTER SHATZ

Mr. BROWN. The statement itself is brief. With your permission, I would like to read it in its entirety.

I appreciate the opportunity to appear here today before your subcommittee to discuss the social security disability program, and specifically the impact continuing disability investigation cases are having on the Tennessee agency.

We have neither the time, nor do I have the recollection, to deal with all the specific and, in my opinion, unfounded charges that have been made against the DDS generally. They may apply specifically in some isolated cases; they do not apply generally. And I may touch on those, as I recall them, in my testimony.

I have been employed in the State-administered Federal social security disability program since October 10, 1955, and administrator since August 12, 1958. I earned a B.S. in health and physical education from George Peabody College in December 1950, and a master's in public administration from the University of Tennessee in June 1975.

Prior to receiving a phone call from the Atlanta Regional SSA Office on March 5, 1981, advising us of the increased emphasis to be given continuing disability claims, CDIs had been an important, but not significant, part of our workload. Until 1981, we processed approximately 3,000 CDI cases each year.

During fiscal 1981, we received 8,840 CDI claims, while processing only 5,891. During fiscal years 1982, 1983, and 1984, receipts are projected for 11,179, 19,747, and 30,896 for those 3 respective years. The increase from 1980 to 1984 will be tenfold.

This unanticipated increase in workload, on top of personalized denial letters, initiated in July 1981, and the concern with volume providers last summer, has had a devastating effect on our agency.

It's a fact of life that the Tennessee Disability Determination Section has been understaffed for at least the last 4 years. From 1978 to 1981, total cases processed increased from 55,444 to 68,128 with no increase in staff. In fact, a State hiring freeze was imposed from March 17, 1980, until 50 new positions were finally approved effective July 1981. During that entire period, numerous efforts were made for additional staff and relief from the freeze, with little or no success.

The foregoing is provided by way of background to describe the climate existing in many States whose overall services and staff were being cut back, as opposed to DDSs, whose responsibility, workload, and fiscal resources were on the increase.

The March telephone call referred to earlier included more than just notification of increased emphasis. The message also advised that, within 2 weeks, accelerated CDI cases would be sent to the agency, and would number 2,500 by July 1 of that year. The total for the period March through September would total 5,000 cases.

The agency was, of course, aware of the 1980 amendments, requiring periodic review of CDI's at least once every 3 years, beginning January 1982, but was unaware and unprepared for the early release. The agency was further advised that this workload had a very high priority.

The agency, had a substantial workload not been on the horizon, was in relatively good shape in March 1981, with 7,473 cases, just recovering from a 25-year high of 9,566 cases 6 months earlier. The agency had absorbed the extra work resulting from paying for evidence of record for title II claimants beginning in December 1980, but was not at all prepared for personalized denial notices, required effective July 1981.

Realizing the high priority assigned to the CDI cases, and having no additional new staff to assign them to, I made the mistake of shifting staff and work to accommodate this workload.

Within another 6 months, the pending workload had increased from 7,473 in March to 14,421 in September 1981, and initial case processing time had increased from 35 days to 60 days. High caseloads and implementing personalized denial letters so adversely affected our performance that for three consecutive quarters, our processing time exceeded the maximum acceptable according to regulation, which brought Social Security on our back because of poor performance.

We were finally able to secure 50 additional positions in July 1981, giving us a total authorized staff of 263. Continuing our efforts to staff up for further increases in CDI receipts for this and the next 2 years, our latest request for 90 positions was reduced to 25, and these cannot be filled until July 1982.

In order to get and keep our regular—non-CDI—caseload in acceptable order, we have had to stack incoming CDI claims, and now have more than 4,000 cases which have only been logged into our case control system, with no development initiated.

Plans are currently underway to assign our quality assurance staff and some more experienced initial examiners to the backlog of CDI claims. Although the workload of initial claims is being under-realized, you can understand our reluctance to assign CDI cases to our regular staff and risk falling from grace again because of unacceptable processing time on initial cases. It's obvious, now that sufficient staff was not approved, that the agency will be unable to process these cases timely. Social Security is well aware of our dilemma, but the cases continue to pour in.

We have asked for some relief. The relief would be only temporary, compared to skipping a car payment. Over a period of time, we would receive the same number of cases. Our dilemma is such that while we are unable to process them, the idea of us or SSA contracting out the development of the cases to a private contractor is not appealing, because the contractor could successfully recruit much of our staff and compete with us for medical sources that are already limited.

I guess it's obvious that the efficiency of the agency has suffered dramatically, if efficiency is measured by initial processing time. This occurred while we were processing all the cases we received, but taking much too long to do so.

Now we are efficient. We are processing initial cases well within acceptable time limits, but have 4,000 CDI cases we have been unable to put into the process.

Despite the regulations, it does appear that Social Security could have accepted some responsibility for accelerating the CDI process in March 1981 which forced us into an unacceptable level of performance. They sent us cases we were unprepared for, then "gigged" us when it adversely affected our performance. Morale during the last 12 months has been the "pits." Much of the staff had been working overtime from November 1979 to October 1981, and were literally burned out, just trying to survive. Now with the media coverage being given the termination of benefits by Social Security and the State agency, and the reestablishment of benefits by the Office of Hearings and Appeals, it appears we are headed for another hot summer.

Despite all that I've said about high caseloads and low morale, the agency's accuracy, as measured by SSA, has been very good. With all the emphasis we and SSA have and are now placing on processing time, there has never been so much as a hint to sacrifice quality. Neither in my 26 years in this program has there ever been a quota established or implied for allowances, denials, continuances, or cessations. Adjudicative climates may have changed, but never a hint of a quota.

We in the States must obviously accept some blame. While we had no choice, I guess, but to accept the accelerated cases, we were given an opportunity to indicate how many of the ongoing periodic review cases we could process. At the time, January 1982, we were optimistic about securing sufficient staff to process the cases. Now we know that optimism was unfounded. At the same time, if either we or SSA contracts out part of the development, we have an instant competitor for staff and medical resources.

The inability or unwillingness of some States to staff up for workloads such as periodic review cases has a long history. Rather than assuming the States want to continue in the partnership, a better approach would be to secure a commitment from each Governor, indicating a desire to continue with the disability program with necessary resources guaranteed, or take the necessary steps to take over any State agency not making that commitment.

Social Security's position seems to be to keep the States in the program at almost any cost. I think it's time to weigh the cost.

Senator **Levin**. Thank you very much, Mr. Brown.

Now, Judge O'Byrne.

Mr. O'BYRNE. Mr. Chairman, members of the committee, I appreciate this opportunity to appear here today and discuss some of my concerns relating to the continuing disability review program as being presently performed by the Social Security Administration and other related problems.

Let me introduce myself. My name is Francis O'Byrne. I'm an administrative law judge stationed in the Chicago South Office of the Office of Hearings and Appeals. I have been an administrative law judge since 1973. I was an attorney engaged in the personal injury and disability field for 20 years before I became an ALJ. So, I've been doing personal injury and related work for the past 30 years.

Since 1973, I have been four times elected vice president of the Association of ALJ's in the Department of Health and Human Services. I was also elected as the president for two terms, and I am the immediate past-president of that association. It is an association of approximately 500 or more of the ALJ's who are now on duty with the Department of Health and Human Services.

Now, there are some small changes in the statement that I mailed to this committee last week.

There is one other change. The president of our association, Paul Rosenthal of Santa Ana, Calif., has advised me that the Association of ALJ's stands behind and adopts my written statement. However, I wish to say that any comments I may make today not contained in the written statement are mine and mine alone.

I do not represent the Department of Health and Human Services, the American Bar Association, or any other group.

Now, I have summarized my statement.

The ongoing review of disability cases, as required by Public Law 96-265, is based upon a gross distortion of fact.

When I first wrote this statement out in longhand, I had originally written, it was based upon a lie. One of the judges in our office said, "You shouldn't say that." But I really still think that when the parties at interest, whoever they were, convinced Congress that we were reversing approximately 50 percent of the cases and that therefore the judges were prodigals and were wasting millions and millions of dollars, giving it to people who were not disabled, I believe that was a lie, because we do not reverse anybody. Our hearings are de novo. We are the first human beings with authority that a claimant meets. The term "reversal" as used by the Social Security Administration over the years makes no sense whatsoever.

Whenever an administrative law judge follows the law and pays a case, that is tabulated as a "reversal." It is as if the statistics were arranged in such a fashion as to make us look silly. And we resent it.

I'll give you a classic example, a classic example of where the State agency was absolutely correct when they denied an application, and I was absolutely correct when I "reversed" it.

I heard a case involving a younger man who had had cancer of the colon. The cancer was excised, and all the doctors involved at that time reported that the cancer had not metasticized—it had not spread. He was a young man. And when he appeared before me, he looked to be in very good health. There was one problem: He could not do his last work. He was either a skilled steel worker or a bricklayer, one or the other. He could not bend or stoop frequently and that is the only limitation he really had. Under the law and the regulations, he was not disabled.

When the hearing was over, I sat down, and I wrote my decision. We had a hiring freeze at the time. By the time it was typed, about 4 to 6 weeks had gone by, and the case was now back on my desk for proofreading. I was about to sign it and mail this decision, denying benefits when I received a phone call from a Congressman's office asking me had I made a decision on a certain case.

I informed the young lady that I would never tell anyone what my decision on a particular case was. When it was mailed, a copy of my decision would be sent to their office, as had been requested by the claimant, and that I did not discuss my decisions with anybody. She insisted, and I was getting a little annoyed with her.

But when she blurted out, "But you don't understand, Judge, he's in the hospital and he's dying," well, she got my attention. So, it turned out that this man was in a hospital, he was in intensive care and, as a matter of fact, he was dying.

I had my law clerk check out all those facts. Two days later I tore up the denial decision on my desk, I drafted a Short Form Allowance, and I thanked God that the family wasn't at the claimant's wake when they might have received a decision from me saying that the man could work. The Social Security Administration classifies that case as a "reversal". That does not make any sense.

When I learned that the Social Security Administration kept their statistics in this matter, I no longer cared what the Social Security Administration said my "reversal" rate was or any other judge's reversal rate was because I don't know what their statistics mean. I don't know if they know what their statistics mean.

All right. Now, let's go back to the statement.

The acceleration of reviews, plus the much higher percentage of newer applications being denied at the State level, has caused a severe strain on the administrative law judges and their clerical staffs. The statistics clearly establish the higher denial rate by the States. Between 1975 and 1980, the denial at the reconsideration level went from 67 percent to 85 percent. The disability standards of the Act had not been amended during that period of time.

Now, during that same period of time, as you might expect, between 1975 through 1980, denial rates at the ALJ level went from 51 percent to 42 percent. As the State agencies were required by the rules they followed to deny more cases, the ALJ's, by the law they must follow, were required to pay more cases.

Now, this strain I've mentioned—and I've set out in my paper—on the hearing capabilities of the ALJ's, in the big scheme of things, is insignificant. The fact that I am concerned about getting out more decisions and my staff feels more pressed, those are problems that I can live with. My problems—although, to me, they're serious—they are insignificant when measured against the needless pain, fear, and heartache caused the claimants and their families who have had their benefits ceased on flimsy or no real evidence.

With regard to these Cessation cases, I estimate that about 25 percent of my pending case load are Cessation cases. At the present time, I have a total of 243 cases assigned to me.

Now, of the Cessation cases that I hear, I find that about 20 to 25 percent of the Cessation determinations, involving physical impairments are correct. However, in regard to mental impairment Cessation cases—I am estimating, again—I believe that I only find about 10 percent of those cases correct.

This means that 75 to 80 percent of the Cessation claimant's who come before me are going to have their benefits restored. And I am or was considered to be one of the conservative judges.

The time period between the Cessation determination and my decision, or the decision of any other ALJ, is the period of time when the claimant and his family is in fear, pain, and heartache.

Not too long ago Mr. Hays, the Associate Commissioner for Hearings and Appeals, informed the House Subcommittee on Social Security that he anticipated that there would be 415,700 hearing requests filed during the fiscal year 1983. He also reported that that would be 50 percent increase over the 1981 level. That's a very big increase. In my opinion, that 50 percent increase will probably be mostly Cessation cases.

If the Congress feels that they have heard cries of pain in 1981 and 1982, 1983 may well prove to be a vintage year for hardship among claimants. There are just not enough ALJ's on duty to quickly remedy this problem. The problem must be cured at the source. Only the Congress can reach that source. I believe the legislation is needed and needed this session.

The reasons for the increasingly high denial rates at the State level and the therefore increasingly higher allowance rates by the administrative law judges are known and have been known to the Social Security Administration for some time.

Among the reasons, I believe the following are most important. These reasons are set out in some detail in exhibit 2 of my statement, which was prepared by Judge Shatz, who is sitting on my right.[1]

The State agencies do not follow the disability standards of the Social Security Act or the published regulations in many instances. The State agencies use different criteria than the Office of Hearings and Appeals and its judges.

Now, recently the Senate passed Senate Bill 1080. That bill was passed, I believe, 94 to 0. That bill was designed to prevent administrative agencies from preparing rules in secret that would have a substantial impact upon the people of our country.

The POMS, the Program Operation Manual System, is the system that the States must use in adjudicating cases. I have never seen the POMS. I don't know of any ALJ's who have ever read the POMS. Yet, those are the standards that the State agencies are using. The ALJ's are using the Social Security Act, the Regulations, and the Rulings. No wonder the figures are different. Further, the States define "burden of proof" and other terms differently than to the ALJ's and the United States District Courts.

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[1] See p. 389.

As you have heard, the States do not consider pain as a disabling factor. The ALJ's must consider and evaluate pain under the Regulations and court decisions. The States, by ruling, must give probative weight to the opinion of a State agency doctor who has never seen the claimant.

Further, the same ruling provides that the administrative law judges are not to write to the family doctor or to an examining doctor and ask him to fill out a form telling us what physical ability the patient has remaining. That is referred to as the RFC, the residual functional capacity. Now that is very important. It flies in the face of reality that a doctor who has never seen the claimant can give a better opinion than the family doctor or an examining doctor.

Now, I have very quickly assembled eight cessation cases from my office—most of which are mine—that are illustrative of why a large percentage of cessation determinations are found to be incorrect.

Now, in the first case that you have, the benefits were ceased because the claimant did not meet the Listings. However, vocational factors were also involved. Whether or not a claimant meets Listings is only part of the disability evaluation process.

In the second case, an independent medical examiner found the claimant could only perform sedentary work. In this particular case, the "Grid" factor—that is, the vocational location factors—also required the ALJ to find the claimant entitled.

Case No. 3 was a young lady who had a grand mal seizure at least once a month and had petit mal seizures everyday. I ordered benefits restored.

Case No. 4, all of the examing psychiatrists and psychologists concluded that the claimant could not work. The case was denied. I also allowed that one.

Up in your territory, Senator Levin—I was hearing cases up in Escanaba, Michigan not too long ago—I had a case where a claimant had had a long, long history of back problems, shown by medical records for 1974, 1975, 1976, and so on. I was holding my hearings in the basement of a motel. The attorney came down to see me and told me that if his client came down the stairs, he couldn't go up. So, we held the hearing in my motel room. This man was ceased because he was a very religious man. He got the idea that God wanted him to go out and work. He obtained a job. He worked for 3 days driving a school bus. Then, because of extreme pain, he could not continue driving the bus. He felt guilty about this. He felt he had kind of let God down, because God wanted him to work.

The man could hardly get in and out of a chair. I was absolutely and totally convinced that this man was suffering from chronic, severe pain. I also wondered why, since the man had been in disability for some years and he had tried to return to work, he had not been granted a Trial Work Period. For some reason, he wasn't. I don't know why. I had no difficulty with this case. This was the kind of case I get occasionally where I am embarrassed at the hearing that the people are there.

Case No. 6 is a case I heard where the woman was 50 years old. When she came into the room it was very readily apparent to me that it was going to be a difficult hearing. The woman didn't know how old she was. I asked her how old she was. I think she said 48. I asked her how old she was 6 months before that, and she told me, "I don't know, 18 or 46." In the language of the street, the woman was "out of it." That hearing lasted about 10 minutes. Her daughter told me that this wasn't a bad day for her mother. On some days she was worse.

Case No. 7 was heard by another judge in our office—I located some of the medical reports on this case. This is a real horror story. This particular claimant was taken to the hearing by a hospital social worker because he never could have gotten there himself. And at the hearing the claimant was incoherent. The judge who heard this case was very upset about it. The medical reports indicated the man should never have been before us.

I am paid well. I am a GS-15. I earn more than $50,000 a year. The people of the United States shouldn't be paying me $50,000 a year to hear cases like this. It's not right. They are paying me money to hear tough cases. That's why I was put on the payroll. I'm sorry if I sound a little emotional about some of these cases.

Case No. 8 is another mental impairment case assigned to our office. Benefits were restored. The judge felt strongly about it. The evidence was so clear that this woman was mentally impaired that he ordered her paid on the record without a hearing.

Now, in my statement I have made eleven suggestions to help remedy some of the problems we face. Five of them should be given your immediate attention as they protect the claimant.

First of all, make it mandatory that the State agency follows the disability standards set out in the Social Security Act and the regulations, and that absolutely no other guidelines or standards be used. Until last week I didn't think I would ask for this, but I now think it's important. I believe that the Congress should create a separate Department of Health and Human Services review commission to prevent the SSA from applying either direct or indirect pressure on the ALJ's. Indeed, to prevent the Social Security Administration from instructing its ALJ's to ignore a decision of the U.S. Circuit Court of Appeals.

Three, require that all future guidelines or standards to be used by the State agencies be published, and there be at least one public hearing in regard to those proposed standards in each of the Social Security Administration administrative regions. I believe the act should be amended to state that the social security hearings shall be conducted on the record and that all ALJ's hearing cases under the Social Security Act at every level shall be ALJ's appointed under section 3015 of title 5.

This is a technical matter. The courts have held that the APA does apply to us. Congress has never really been that explicit. More importantly, that the present accelerated reviews be slowed down until such time as the average ALJ caseload can be reduced to a level of approximately 130 cases per judge.

Now, I have a series of cases in my brief case, but I don't have time to describe them. You heard enough here today. This problem is not a problem of Chicago or Escanaba, Michigan or St. Joseph or

Gary, Indiana. Those are areas where I recently heard cases. I am in Chicago most of the time. I go to St. Joseph about every 3 months. This is a nationwide problem.

The Office of Hearings and Appeals has recognized this problem. In the Santa Ana, California office there is a special unit that does nothing but screen the incoming cases for obvious pay cases, so that they can quickly pay them on the record. The Office of Hearings and Appeals knows about the problem. They are trying to cooperate as much as they can, with the limited staff they have, to catch these cases. In our office we just don't have enough staff to set up a special unit to identify them that quickly. Of course, the cases have been in a cessation status for some time before they come to us.

That concludes my statement.

Senator LEVIN. Thank you. You heard testimony earlier this morning that in the opinion of the Social Security Administration, it's proper to direct administrative law judges and others at the State level to ignore decisions of courts of appeal.

Mr. O'BYRNE. I was a lawyer for a long time before I became a Judge, and I am very nervous about ignoring orders of courts. Now, in a way I am lucky. I am not in the Ninth Circuit. But if I was an ALJ in the Ninth Circuit, I would wonder, for example, if I was a member of the Bar in California, what would happen if I deliberately ignored a court order in my own home State. Could I be suspended from practice? Could the judge hold me in contempt and lock me up? I don't know what I would do if I was there. I just have this gut feeling that it is wrong. It has to be wrong. If the Social Security Administration goes to court and they win, they win. It just doesn't seem right that if you go to court and lose, you can still win. We should have a government of law, not of men.

Senator LEVIN. What law are you bound by your oath to follow?

Mr. O'BYRNE. The Constitution of the United States.

Senator LEVIN. And the laws enacted pursuant thereto.

Mr. O'BYRNE. Correct.

Senator LEVIN. Now, if the laws enacted pursuant thereto, as interpreted by a court decision, conflict with whatever directives you are given in some new directive as to what the law is, whether you call them POMS or whatever, what will you obey?

Mr. O'BYRNE. I obey the law of the United States.

Senator LEVIN. If the Social Security Administration gives you a manual that says that this is the way you will consider paying and this is the way you will consider vulnerable problems and this is the way you will do other things, and if that manual conflicts with the laws of the United States, as you interpret it, what would you do?

Mr. O'BYRNE. I would ignore the manual. Now, that is one of the interesting problems that is going to develop. The ALJ's are bound by the act, the regulations and the ruling. The rulings do not have to be published. Now, if a ruling contradicts the regulations or the act, it's very easy for the ALJ to state so and ignore it. But in borderline areas, it might be more difficult to do so. But clearly, if a ruling contradicts the act or the regulations, I don't think any ALJ would obey it. I would not.

You see, there's a part of me that's an employee. I keep regular hours, annual leave, and so on. But there's another part of me that's a judge, and there are certain areas where, as a judge, I wouldn't take orders from anybody except the Congress of the United States and the courts.

Senator LEVIN. Has there been anything in writing on the issue of whether an ALJ, confronted with a conflict between the laws, the regs, as he or she interpreted it, and the manual of the agency of which they are serving a function, must follow one or the other? Have you seen anything in writing on that issue?

Mr. O'BYRNE. No, Senator, I have not.

Senator LEVIN. Is that because it's so obvious as to which one should be followed, or it's just never been raised?

Mr. O'BYRNE. It would appear to me to be obvious. Incidentally, at the American Bar Association convention in San Francisco in August, that may be the subject of a panel discussion. When is a judge a judge and when is he an employee?

Senator, is it all right if Judge Shatz makes a brief reply?

Senator LEVIN. We're going to have to leave the room in just one moment, so if you could hold off for just one second, I wanted to ask Mr. Brown a question or two first.

Would you agree that State disability examiners in fact use different standards than the ALJ?

Mr. BROWN. Yes, without a doubt.

Senator LEVIN. Aren't State disability examiners required to follow the case law?

Mr. BROWN. Not to my knowledge. We're not even aware of the case law.

Senator LEVIN. If Congress appropriated more money for State staff, would you be able to use it even though there might be a State hiring freeze?

Mr. BROWN. You have already appropriated, and there is more money available to our particular State that we can use. I guess there's been some misunderstanding that all you need to do is offer the States money and they'll staff up.

Senator LEVIN. Why shouldn't the States staff up if we offered 100-percent payment for it?

Mr. BROWN. It's not 100 percent, it's 125 percent.

Senator LEVIN. I didn't mean to cheat. Why shouldn't the State staff up if we ordered more than enough to pay for it?

Mr. BROWN. I wish I knew, because that occurred at a time when the government was expanding. My presumption has been if I could get to the right person in the State and explain this program and its benefits in the funding, someone would say, "I didn't understand it that way. That makes sense, we'll do that." This has been going on for years and I do not know the answer to it.

Currently, with the size of government being reduced, we're going upstream when we get staff. If we had an additional 100 people in our department and the department is trying to reduce staff by 200, you can see what kind of effect that would have on the problem.

Senator LEVIN. What do you do if there's a conflict between the consultative examination and the treating physician's report? Which one do you follow?

Mr. **Brown**. The first part of the question, the part about the conflict?

Senator **Levin**. If there's a conflict between your consultation, the State consultative report and the treating physician's report——

Mr. **Brown**. If the attending physician report comes in first, and invariably they almost always will, then we would accept that if it was detailed and complete and there would not be a need to provide a consulting examination. The problem is a fairly comprehensive CE report compared to an attending physician's report that probably is not that detailed.

Senator **Levin**. Do you ask for more detail from that physician if it's inadequate in that regard?

Mr. **Brown**. Sometimes we do and sometimes, because of the pressure of cases, we don't go back. We have a number of years of experience with physicians, and we know that what we get the first time is all they have. If an attempt is made to go back and get a description of chest pain, it's extremely difficult. It may be easier to send the person for a consultative examination and get the whole thing wrapped up at that time.

I would like to dispell, if I could, the idea that we completely disregard the attending physician's report, and that we rely wholly on CE's. That is not the case, and I can statistically prove that. Most of our decisions are made without the benefit of consultative examinations.

Senator **Levin**. If there's a conflict, again, between the two, which one would you follow?

Mr. **Brown**. We would take it to our State agency physician. If that can't be resolved, then we would go back to the attending physician if there is a conflict in findings, not in opinion.

Senator **Levin**. Let me just ask one quesiton of you, Judge O'Byrne. This own-motion review process that's been going on here recently, I read a couple of times this morning a memo which said starting on October 1, 65 ALJ's were selected for review, and I'm quoting the memo. Those ALJ's who were selected were either the highest individual allowance rates or come from hearing offices with the highest overall allowance rates. Are you familiar with that?

Mr. **O'Byrne**. I'm somewhat familiar with it. There are, I believe, four offices in the State of Pennsylvania, where every single judge in the office is on a 100-percent check.

Senator **Levin**. Was the selection of those judges, in your opinion, motivated by the desire to make a point about judges who grant more allowances, or was that just done at random with no particular point in mind?

Mr. **O'Byrne**. On the face of it, it would seem that the selection process was tilted. I don't know what the motives of the men were who chose them, but when they selected these judges who had "high reversal rates" and no one else, it would indicate that they were—or someone was trying to chill that rate and bring it down.

For example, if I knew that I was being checked on every single word I wrote, it would slow down my drafting. The man who was given the job to check me, if he were human, would assume there was probably something wrong or they wouldn't have asked him to check me, and by God, he's going to find something wrong because that's his job. That sure would slow me down. I would be very, very careful of everything I wrote because I would know that some expert would be pouring over it trying to find something wrong with it.

Senator LEVIN. Was there discussion among the ALJ's about the selection of specific ALJ's for that own-motion review?

Mr. O'BYRNE. The ALJ's thought if they were going to check the decisions of the judges at one end of the spectrum, that they should also check the decisions of judges at the other end of the spectrum; or even better, that all decisions be randomly checked.

Senator LEVIN. Was there discussion of this particular memo where it said the own-motion review would be for those ALJ's with the highest individual allowance rates? Was that a subject of discussion among the ALJ's?

Mr. O'BYRNE. I don't know if we ever received that memo.

Senator LEVIN. So that was not well known among the ALJ's?

Mr. O'BYRNE. I think we found out later.

Senator LEVIN. After you found out about it, was it a subject for discussion?

Mr. O'BYRNE. Oh, yes. At one of the board meetings of our association it was brought up. We had objected to it, and Mr. Hays gave the same explanation he gave here today, that they had to start somewhere. These judges were taking on more cases and there was probably a likelihood of more error there.

Senator LEVIN. And what was your response to that?

Mr. O'BYRNE. My response was it has not changed. We thought that if they were going to check one of them, they should check the other; that it would be even better if there had been a random checking of cases.

Senator LEVIN. Are there notes in existence of that meeting?

Mr. O'BYRNE. I am sure somebody has some notes.

Senator LEVIN. Could you try to make those notes available to us?[1]

Mr. O'BYRNE. I will try, Senator.

Senator LEVIN. Thank you.

Judge, we just have a moment, because we are going to be kicked out of this room.

Mr. Shatz. I just want to take one second. My name is Judge Shatz. I wanted to respond to the Circuit Court of Appeals problem.

We always have that problem within the agency nationwide. Now, some judges cite the Circuit Court of Appeals decision. They say even though it's unfair, I'm bound by the agency policy, et cetera, et cetera. But they give the claimant the procedure to follow for appeals to court.

The trouble with that policy, it's unfair because the people that have the money and the tenacity to further appeal that case from the agency will ultimately win in the United States District Court because the District Court judge is going to follow the Appeals Court. But the other people that do not have the tenacity aren't going to appeal, and it seems to me that policy, therefore, tends to have a discriminatory effect.

Senator LEVIN. I want to thank all of you.

Yes, Mr. Brown?

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[1] Notes referred to not available at time of printing.

Mr. **Brown**. I need about 20 seconds. My concern is that we are perpetuating some misunderstandings, and we should be getting to the root of it. I don't think we have. One has to do with the claimant on a CDI case having to prove his claim. I never heard that before, until today. Also, I never heard before that we disregard the original medical in a CDI claim. We review the entire claim. Where that idea came from, I don't know, but these are some major points that I think have been misunderstood or misconstrued here.

Senator **Levin**. Are you saying that the claimant does not have the burden to prove his claim on CDI?

Mr. **Brown**. No. If he did, we wouldn't be buying consultative examinations. We feel like the burden is up to the Government.

Senator **Levin**. Has that been stated anywhere, as to who has the burden?

Mr. **Brown**. I'm not certain whether it has or not. In practice, that's the way it's applied.

Senator **Levin**. There's nothing to give you any direction on that issue as to who has the burden?

Mr. **Brown**. Yes, but it's different for title 2 and title 16. Generally, the broad responsibility is for DDS to secure the medical information.

Senator **Levin**. Let me just tell you that it's our understanding that Tennessee is the exception as to who has the burden on that issue, and it's very interesting that there is no direction on it that's intelligible. It's led to a lot of heartache, as you phrased it, Judge, this morning, in one of the areas that should be looked at very quickly, and will be the lack of direction on that issue as to who's got the burden in the CDI cases. All regions got together on that issue. I think we might at least have a somewhat different problem than we have.

Mr. **Brown**. I can't speak for even our region, but it would surprise me if Tennessee were the exception.

Senator **Levin**. Well, that's what my staff indicates to me, that that is the exception.

Mr. **O'Byrne**. Senator, we're running out of time. I want to refer you to exhibit 5. I consider it to be extremely important. It is the first time I have ever heard of, in the history of the Social Security Administration, that the administration ever asked the judges to do anything that I consider to be unethical. We have been asked to send out a form letter on cessation cases, exhibit 5, pages 5, 6, and 12, informing the claimants that a decision in their case has been revised. My staff would have sent this form out, but I happened to catch it. I have not made a decision on that case and the Commissioner of Social Security does not have the authority to tell me when an individual claimant's disability ceased.[1]

And it goes on, "we," "we have revised." Who is "we?" We are the judges. Any unsophisticated claimant would get the idea that the judges had decided his case before he even appeared at a hearing. Then at the bottom, the claimant is given the marvelous opportunity to waive his due process rights to a hearing. I just couldn't believe this when it came in.

Senator **Levin**. Have the administrative law judges reacted as a group to that letter, to that form?

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[1] See pp. 409–419.

Mr. O'Byrne. The judges in our office have reacted very, very strongly. We will not do it.

Senator Levin. Is there a letter back to the Social Security Administration on that matter?

Mr. O'Byrne. When the first letter came out to our office, Judge Sprague of our office, wrote a letter to our Chief Administrative Law Judge, Philip Brown. Judge D'Amico of our office also wrote to us. A copy of that memorandum was mailed on that date to our Acting Regional Chief Judge.[1] I believe that Judge Charles Bono of Kansas City has written to Mr. Hays.

Senator Levin. Has that letter of Judge Sprague to Judge Brown of April 26 been answered?

Mr. O'Byrne. As of yesterday afternoon it had not been.

Senator Levin. Could you submit a copy of it to this procedure?

Mr. O'Byrne. Yes.[2]

Senator Levin. Again, there are so many questions we'd like to ask, but the time now is 2 o'clock and this room must be made available for another purpose. We want to thank you for your patience, at least your apparent patience. You've hidden your lack thereof very well. You have a right to be, given the time delay in getting to you this morning.

Judge O'Byrne, let me raise a question, though. Why are they paying you to handle these obvious cases? I think you've proven very well today why we are paying you, and the other witnesses, since you raised the question specifically about how silly you feel collecting a check when you're simply reversing, as you would put it, an allowable benefit when the States have disallowed it. Let me assure you that you're earning your check very well. I say that without any disparagement of any of our other witnesses, but since you seemed to raise the question, let me assure you—Mr. Brown, I don't have to give you your assurance. You apparently don't feel any doubt about your paycheck. [Laughter.]

We're glad that all of you were here this morning, and again, thank you.

[The prepared statement of Judge O'Byrne follows:]

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[1] Material referred to appears on p. 415.

[2] Not available at time of printing.

# STATEMENT OF
# FRANCIS J. O'BYRNE, SR., ADMINISTRATIVE LAW JUDGE
MAY 25, 1982

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

ROOM 1318 DIRKSEN SENATE OFFICE BUILDING

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Mr. Chairman and members of the Committee, I appreciate the opportunity to appear here today and discuss some of my concerns relating to the continuing disability review process as being performed by the Social Security Administration (SSA) and of other related problems.

Let me introduce myself. My name is Francis J. O'Byrne, and I am an Administrative Law Judge (ALJ) stationed in the Chicago-South hearings office of the Office of Hearings and Appeals (OHA), SSA. I have been an Administrative Law Judge since 1973.

The views I express today are mine. I do not speak for the Department of Health and Human Services, the Social Security Agency, the Office of Hearings and Appeals, the Associations of Administrative Law Judges (HHS) or on behalf of the American Bar Association.

I have attached the statement of Judge Chester Shotz given before the House Select Committe on the Aged on May 21, 1982. It is marked as Exhibit Two (2). I incorporate his statement by reference.

You are aware there is an accelerated disability case review in progress as required by the Bellmon Amendment requiring the Social Security Administration to review cases in pay status. Based upon comments in the press by members of Congress, the congress did not anticipate the vigor that the Social Security Administration would apply to that task.

The Bellmon Amendment itself was based upon a gross distortion of fact. The Congress was informed by the Social Security Administration that the Administrative Law Judges of the Social Security Administration (SSA) were "reversing" fifty or more percent of all the cases coming before them for hearing and therefore millions of dollars were being paid to claimants who were either never disabled or whose disability had ceased. In the language of the street we were being given a "bum rap".

The Administrative Law Judges do not "reverse" any one. We are not an appellate body. Our hearings are "de novo". The closest we come to what could be termed a "reversal" is when we order benefits paid without holding a hearing and based upon the same evidence that had been considered by the state agency. We call these "payments on the record". They once were fairly rare. They are not rare today.

When ever an Administrative Law Judge obeys the law and the regulations and finds benefits due, the Social Security Administration tabulates that case as a "reversal". This is nonsense. I have attached a letter from Mr. Louis Hays, Associate Commissioner for Hearings and Appeals, of July 21, 1981 and my reply of August 5, 1981, to illustrate this absurdity (Exhibit 3).

In here today becuase Congress has the power to alleviate the developing hearing crises and the needless pain caused by the present ongoing accelerated review of disability cases in pay status.

Every crisis we have had since 1972 ends up on the shoulders of the Administrative Law Judges. We had no control over the fact that 72,000 Black Lung cases came to the OHA in one year. We have no control over the number of cases we get for hearing. At the same time if the cases are not heard and decided quickly, it is our fault. Since 1972 the ALJs have performed wonders. We are then asked, can't you do more, and if you do not dispose of another 5, 10, or 20 cases per month, the hearing system will be changed by Congress and you will be looking for a job. This doomsday talk has worn thin over the years, but we still hear it.

It is, however, a disturbing threat as most of our ALJs are in the final third of their lives and have given up their past work or law practice and many have moved away from their homes to different cities or states. We

AlJs are proud of our corps, proud of our work, and becoming an ALJ has been the crown of our legal career. We are a proud and a competent corps because we were merit selected and every ALJ on duty was a trial attorney.

The acceleration of reviews plus the higher percentage of cases being denied at the Reconsideration level has and is causing a severe strain on the judges and their clerical staffs.

The OHA pressures the ALJs for "production" that is for increased case closings. A "high producing" office is an office that closes a high number of cases each month. A "high producer" is a judge that closes a large number of cases each month. It is as if all the judges sat at machines that produced decisions.

About five (5) years ago, the OHA let the ALJs know that the "production" goal was 26 cases per month per ALJ. Now we are advised that the goal is 40 to 45 cases per month. Most judges have met the prior goal and now average about 30 decisions per month. This was achieved because the OHA provided the ALJs with additional clerical staff, word processing equipment, and attorney advisors. Attorney advisors assist in drafting decisions.

The judges have responded to the needs of the times. In 1973, working without an attorney advisor, I closed about 15 to 19 cases per month. Working with an attorney Advisor I issued about 31 decisions per month in 1981. During the first four months of 1982, I have averaged 41 dispositions per month. In April, I closed 59 cases.

I can not maintain this level of average monthly decisions for any extended period of time. In order to close 166 cases through April of 1982, I have come to the office early, have worked on Saturday, traveled to out of state hearing sites on my own time, and worked a 70 hour week on a hearing trip to Wisconsin. Judges all over the country have been making this extra effort because we wish to accomodate the claimants waiting for a hearing. The judges do not get paid for over time or receive compensatory time.

At the end of each month the "production" figures of all the judges are added up and an average "production" rate determined. The 59 cases I closed in April will have gone into this total average. Any judge below that new average is urged to increase production to meet the average. Therefore the judge that works extra hours or days finds that his increased "production" is being used against another judge. Years ago this was called the "speed up" in factories.

At the present time I have over 243 cases assigned to me. In April I was assigned 108 new cases. For some months now about 25 percent of my pending cases have been cessation cases. I estimate that about 20 to 25 percent of these cessation determinations will be correct and almost all of these correct cessation determinations will involve physical impairment cases. I estimate that 10 percent or less of the mental impairment cessations will prove to be correct. I have had a few cases where a claimant has been receiving disability benefits since 1974 and who, in my opinion, was never disabled. In a much higher number of cases, I do not understand how any reasonable person following the Act, the Regulations, and the Social Security Rulings could have found a claimant's disability to have ceased.

My experience is not unique. Our Santa Ana, California office has set up a special screening process with the blessing of OHA management to identify obvious "pay cases" and to get them closed; the problem is nation wide.

The strain the acceleration of review has caused on the OHA and the ALJs is insignificant when compared to the pain, fear and heart ache caused to the claimants who have had their benefits ceased on flimsy or no real evidence that their disability has ceased. The speed at which the acceleration process has been implemented has caused needless misery across this land. There are not enough ALJs on duty to quickly cure the problem. The problem must be cured at its source. More care and time must be spent on cases before the disability cessation determination is issued. The opinions of consultative examiners must be given more weight at the state level as to residual functional capacity. The state agencies often ignore the results of medical examinations that they have requested. The ALJs suspect, but can not prove, that the states are following the rules given to them by the SSA.

Because of the Administrative Procedure Act, the ALJs enjoy a much greater degree of independance and security than state agency personnel. Because of this independance we have been able to restore thousands of claimants to benefits status who should never have been terminated. We believe that if it were not for the Administrative Procedure Act the present serious hardship problem would be far worse. The claimant's right to a fair hearing is the only real safe guard he has.

Attached you will find copies of some memorandums from closed files that illustrate why the ALJs have found such a high percentage of cessation determinations to be incorrect. The supporting medical reports referred to are no longer available in our office. Names have been removed for obvious reasons. ALJs hearing cases in your respective states, upon request, would provide you with examples close to home. These are not the most flagrant examples, they are the cases I could find in a hurry between hearings. Attached as Exhibit 4, cases 1 through 8.

Case No. One

Disability ceased because he could return to his past relevant work of a sedentary nature. The fact is that his past relevant work was not sedentary, it was light. That determination was revised. It was then found the claimant could only perform sedentary work, but that disability ceased because the claimant no longer met Listings. This revision was not correct as the Regulations also provide that vocational factors be considered. They were not.

Case No. Two

Similar to No. One, but no revised determination.

Case No. Three

This claimant met Listings.

Case No. Four

The consultative psychiatrist and psychologist both concluded this mentally impaired young lady could not work.

Case No. Five

This claimant was ceased after working for three days. He could not drive a bus because of severe pain. At the hearing he had great difficulty moving in and out of a chair. The medical evidence established that disability continued. Pain was a very important disabling factor here. The states do not considere "pain".

Case No. Six

a severe mental impairement. She did not know her age.

~~The consultative examiner found the claimant was limited to sedentary work. The vocational factors mandated continued payment.~~

Case No. Seven

I did not hear this case. Another ALJ in our office heard this case. The claimant was ceased when a state agency physician who had never seen the claimant found this claimant could perform simple tasks at a competitive rate under normal supervision. The treating doctors reported the claimant could not handle non-sheltered employment or manage his own funds. Another doctor stated the claimant could not function in a sheltered work shop because the claimant would run away and yet another doctor stated the claimant could not carry on a conversation. The claimant was brought to the hearing by a hospital sound worker. The claimant was incoherent.

Case No. Eight

Another ALJ in our office ordered this cessation case to be paid on record. Evidence as to the claimant's severe mental impairment was ignored.

There has been an increase in the number of hearing request coming to the ALJs on cessation cases and on initial applications for benefits because:

1. The state agencies do no follow the disabilty standards of the Act or the Secretary's published Regulations (See Exhibit 2, pages 3 - 5).
2. The state agency uses different criteria than the OHA in determining disability; the states use the "POMS" (See Exhibit 2, Page 6).

3. The definition of "burden of proof" used by the state agencies and by the OHA's differ. (See Exhibit 2, Pages 6 - 7).

4. The state agencies, at times, avoid or ignore the vocational factors involved (See Case No. One and Six).

5. The states, at times, ignore adverse findings of consultative medical examiners, (medical examiners who have examined a claimant at the request of the SSA) (See Case No. 4).

6. The state agencies and the OHA have a different interpretation of a "non severe" impairment (See Exhibit 2, Page 7).

7. The state agencies do not consider pain as a factor in determing disability, see Exhibit 2, Page 7 - 8, and therefore, ignore Regulations and court precedent.

8. The state agencies give more weight to the opinion of a state agency physician who has never seen the claimant than it does to a consultative examiner who has reviewed the medical evidence and examined and tested the claimant.

The effect of the above has been reflected in the statistics. Between 1975 and 1980 the Reconsideration denial rate went up from 67 percent to 85 percent and the ALJ allowance rate increased from 49 percent to 58 percent, see Exhibit 2, Page 5. The ALJs are of the opinion that we are receiving a significant number of cases, 25 percent or more, that should have been allowed at the state level as where the cessation determination would not have been made if the state agencies had more staff and more time to develop evidence. The state agency employees and examiners are as much victims of the present systems as is the OHA. The state agencies get their disability standards from the SSA.

Meeting the heavy and ever increasing case load has not been with out cost. My decisional quality is not as good as it once was. I do not have time to polish decisions. Instead of striving for good to very good decisions. I Have to settle for good enough. I have shortened my opening statements at hearing and do not have time to prepare written questions for the claimant or a witness in advance. There is less time to spend on each decision. I am sure the processing time of my cases has become longer and that the period of time between the hearing request and the hearing has been extended. My hearing assistant is preparing about 40 cases per month for hearing and she can no longer screen the cases and prepare summaries as carefully as she did in the past.

In order to solve or alleviate these problems and respectfully suggest legislation be prepared to:

1. Make it mandatory that the state agency follow the disability standards set out in the Social Security Act and the Secretary's published Regulations and that no other guide lines or standards be used.
2. Create a separate Social Security Review Commission for the following reasons:
    - A. To prevent the SSA from applying direct or indirect pressure on the ALJ's decisional independance, see Exhibit 5.
    - B. To prevent the SSA from instructing its ALJs to ignore court decisions, see Exhibit 6.
3. Require that all future guide lines or standards to be used by the state agencies be published in the Federal Register and that there be at least one public hearing in regard to said proposals in each of the SSA administrative regions.
4. That the claimants be given an opportunity for an oral presentation at the state reconsiderations level.
5. That the ALJs be given authority to retain for hearing or to remand cases to the state agency when a new impairment is raised before the ALJ but was not raised before the reconsideration determinations was issued.
6. That the ALJs be given the authority to dismiss a request for hearing at the ALJs sole discretion when a claimant does not appear at a hearing after having been given due notice.
7. That the ALJ be given the authority to dismiss an application for benefits where there is no justiciable issue.

8. That all ALJs be at the GS-16 level. This is more a matter of pride than it is money as about one half of all GS-15 ALJs are at the pay ceiling at the present time.

9. The Social Security Act should be amended to state that all SSA hearings shall be conducted on the record and that all ALJs hearing cases brought under the Social Security Act at every level shall be ALJs appointed under Section 3105 of Title V.

10. That the present accelerated reviews be slowed down until such time as the average ALJ case load can be reduced to a manageable level, about 130 cases per ALJ.

11. That the ALJs be given authority to receive evidence in existence prior to the date of the Reconsideration Determinations, but not presented to the state agency to remand the case back to the state agency for a revised Reconsideration Determination.

Thank you,

Francis J O'Byrne Sr.

Francis J. O'Byrne, Sr.
Administrative Law Judge

[Whereupon, at 2:05 p.m., the hearing was adjourned.]

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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[illegible] CHAIRMAN
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United States Senate
COMMITTEE ON
GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON
OVERSIGHT OF GOVERNMENT MANAGEMENT
WASHINGTON, D.C. 20510

April 27, 1982

The Honorable Richard S. Schweiker
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

On Tuesday, May 25, 1982, the Oversight of Government Management Subcommittee will hold a hearing on social security Title II disability benefits terminations. The hearing will focus on the Social Security Administration's (SSA's) decision to accelerate the required review of disability cases, its continuing management of those reviews, and the resulting impact on claimants.

In preparation for that hearing, we are requesting that you forward to the Subcommittee by May 3, 1982, the following information:

1) Copies of all memoranda, policy directives, guidelines, and regulations sent by the national SSA office to regional and state agencies regarding the implementation and management of the accelerated review of disability cases, including specific plans for staffing, training, and budgeting to accommodate the increased reviews.

2) A detailed, step-by-step description of the entire disability review process, beginning with case selection, proceeding through the hearings and appeals stage, and indicating the personnel responsible for each step of the process, and the average amount of time which elapses between each step.

3) Copies of those portions of the Social Security Claims Manual (or POMS) which govern disability reviews and terminations generally.

In addition, by May 10, 1982, please provide the Subcommittee with the answers to the following questions:

1) What was the specific rationale for the decision to begin disability case reviews in March 1981, rather than January 1982, as required under the 1980 amendments to the Social Security Act?

2) How did the SSA prepare itself for the increase in reviews in March 1981, and for the continuing increases anticipated in 1982, 1983, and 1984? Specifically:

a) What changes in staffing were made to accommodate the increased reviews, both in the review and the hearing and appeals process? Please provide the specific numbers of staff assigned to the case review process, including hearings and appeals, for each fiscal year from 1979-1982, and projections for fiscal years 1983 and 1984. These staffing numbers should include administrative staff as well as claims representatives, disability examiners, staff physicians, administrative law judges, staff counsels, and other staff. Please specify the number of staff by category and provide a brief description of their respective functions.

b) What budget changes have been made and are planned in order to pay for increased case reviews? Please provide specific budget information on staffing, training, and administration for the case reviews for each fiscal year from 1979-1982, and planned budgets for fiscal years 1983 and 1984.

c) What additional staff training was instituted or is planned to meet the increased case reviews both in the review and the hearings and appeals process? Please provide specific training requirements, schedules, and continuing training plans.

3) Please provide the following for the period starting March 1981, to the present:

a) number of cases selected for review;

b) number of cases actually reviewed;

c) of cases reviewed, number where consultative examinations were conducted;

d) number of cases where benefits terminated upon review;

e) of cases where benefits were terminated, number where consultative examinations conducted;

f) of cases where benefits were terminated, specify number terminated for following reasons:

i) evidence of medical improvement;

ii) evidence that claimant engaged in substantial gainful employment;

iii) other reasons -- please specify.

4) In March 1981, the General Accounting Office (GAO) issued a report entitled "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries." In comments on that report, SSA listed several specific steps SSA had taken or planned to take to prepare for additional continuing disability investigations. Please provide the following information:

a) SSA indicated that in 1980 a national review of 25,000 Title II disability cases was instituted to identify typical beneficiaries most likely to be found ineligible. What were the results and conclusions of that review? What types of beneficiaries were found most likely to be ineligible, and on what specific criteria was that finding based? How are the findings of this national study used in selecting cases for review?

b) Similarly, the SSA stated that it had completed a review of 3,000 Title II disabled beneficiaries to determine payment error rate and to permit profiling of high-risk cases. Please provide a copy of the results of that review, including specific characteristics, and its uses since it was developed.

c) At the same time, the SSA noted the need to better identify high-dollar error in Title II cases and had developed case profiles to accomplish that. Please provide a copy of those profiles and an explanation of the specific criteria for their development.

5) In the current review of disability cases, please list the specific criteria for selecting cases. If any one criteria or combination of criteria triggers selection, please indicate the number of cases selected according to each criteria or combination of criteria.

6) For each of the fiscal years 1979, 1980, and 1981, please provide the average number of days between:

a) notice of initiation of case review and notice of termination of benefits;

b) notice of termination and reconsideration;

c) reconsideration decision and appearance at ALJ hearing;

d) ALJ hearing and ALJ decision;

e) ALJ decision and Appeals Council determinations.

7) Please provide a list for each fiscal year 1972 through the present of the rate of ALJ reversals of state agency decisions of initial determinations and CDIs.

8) In October 1979, the GAO issued a report entitled "Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability," which criticized the SSA's monitoring of the consultative examination procedures and the doctors who provide them. How is the quality of consultative examinations assured at the state level? What specific ways of monitoring the selection of consultative physicians and the thoroughness of examinations have been instituted at the SSA since that report, and in anticipation of the increased CDI reviews? Please provide copies of guidelines, regulations, policy directives governing state agency selection and reimbursement rates for consultative examinations. What is the current average payment for a consultative examination? Is payment determined by the length or complexity of the examination?

We plan to request that the Commissioner of the Social Security Administration appear at our hearing. As the date for the hearing draws closer, we will provide you with more specific information. In the interim, we await your prompt response to this request. Please have your staff contact Barbara Savage, the Subcommittee minority counsel, at 224-3682 before they begin to prepare this response. Responses should be mailed to the Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, 3306 Dirksen Senate Office Building, Washington, D.C. 20510, or delivered to the Subcommittee office at 506 Carroll Arms, 301 1st Street, N.E.

Thank you for your help.

Sincerely,

Bill Cohen
William S. Cohen
Chairman

Carl Levin
Carl Levin
Ranking Minority Member

WSC:CL:bds

cc: Mr. John A. Svahn, Commissioner
Social Security Administration

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

MAY 17 1982

Honorable Carl Levin
United States Senate
Washington, D.C. 20510

Dear Senator Levin:

This is in further response to your letter of April 27 to Secretary Schweiker requesting information on continuing disability investigations. The enclosed material responds to the last eight questions in your letter. The numbers on the tabs correspond to the numbers of the questions.

This material is being sent separately to Senator Cohen.

Sincerely,

John A. Svahn

Enclosures

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**NOTE: Policy directives manuals and statistical information received earlier are retained in Subcommittee files.**

1. The specific rationale for accelerating the required reviews of disabled beneficiaries is described in the March 13, 1981, memorandum from Fred Schutzman to the regional commissioners and in SSA Program Circular No. 862. Both of these documents were sent to you on May 10 in response to the first set of questions in your letter of April 27.

# MEMORANDUM

SOCIAL SECURITY ADMINISTRATION

DI-12

TO : All Regional Commissioners

DATE: MAR 13 1981

REFER TO:

FROM : Fred Schutzman
Acting Deputy Commissioner (Operations)

SUBJECT: Implementing the Administrative Initiative in President Reagan's Economic Recovery Plan--Accelerating SSA's CDI Effort--ACTION

Attached is a decision memorandum I have signed which reflects our plans for getting the maximum number of title II continuing disability cases consistent with the present budget into the hands of the DDS's during the remainder of FY 1981. Also attached is information about how much each region must add to DDS staffing in order to process the FY 1981 cases. I am asking you to take these numbers and allocate them to the States in your region. Please note that these staffing targets are already funded in the allocations you have received. Further, the money already allotted for consultative examinations will be adequate to cover the cases being sent out.

The States should receive the title II cases shortly. Until they do, they should continue to work as many as possible of the nonrollback conversion cases already on hand. We plan to keep the pipeline full of title II cases. Should any State run out, however, they should process the nonrollback conversion cases until a new supply of title II cases reaches them.

You should continue your planning for FY 1982. We will get to you with the details concerning projected caseloads and staffing needs as quickly as possible.

We are developing a Program Circular to be distributed SSA-wide to describe the background and importance of this large scale effort. This will take some time to print and distribute. In the meantime, because DO understanding is a key factor in the success of this endeavor, I ask that you communicate with them through your channels to explain the large savings to the trust fund that will result as incorrectly paid beneficiaries are removed from the rolls and to prepare them to deal with the inquiries which can be expected.

I appreciate your prompt and thoughtful responses on increasing DDS staffing. Please keep us informed of any issues requiring central office action.

Attachments

# MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

DI-12

ES/E
SJ

TO : Acting Deputy Commissioner (Operations)
Through: EE

DATE: MAR 6 1981

REFER TO: SJH-5

FROM : Sandy Crank
Associate Commissioner
for Operational Policy and Procedures

SUBJECT: Periodic Review and Increasing Title II Disability Savings in FY 1982—DECISION

## ISSUE

How shall we select cases for periodic review while increasing title II disability savings for FY 1982?

## FACTS

Section 311 of P.L. 96-265 requires us to reexamine all title II disability cases at least once every 3 years except for those in which the disability is permanent. Those cases are to be reexamined at other appropriate times. While section 311 applies only to title II cases, the Senate Finance Committee Report states that it expects this review to be extended to title XVI cases as well.

In recent weeks it has become clear that one of our most important goals for FY 1982 and following is to save disability dollars, particularly title II dollars.

The purpose of this paper is to lay out a plan for accomplishing our periodic review mandate while at the same time achieving our goal of saving as many title II disability dollars as possible.

## DISCUSSION AND RECOMMENDATION

Our earlier attempts at coming up with a way to deal with the periodic review workload focused on beneficiary characteristics. Thus, we came up with a set of characteristics which could be identified through our systems and screened out. The remainder of the cases would have to be looked at and those having certain medical conditions which we believe to be permanent excluded. The cases that were left (we estimated about 2.3 million of the total 4.8 million cases on the title II and title XVI rolls) would be subject to periodic review over the 3-year cycle. As soon as the results of the 25,000 case probe of title II cases (on which much information is being gathered) were available, we intended to shift our focus to the cases the probe showed us should be most productive.

DID NOT CLEAR OC E/S

While this approach might be correct in defining the population subject to periodic review, it did not contain any plan for targeting the review on the cases with the most potential for saving money. Accordingly, we set about constructing a plan that used the only available information (the results of OA's DI pilot) which divided the title II population according to benefit amount as well as other characteristics. We proposed to use these "profiles" on an interim basis until such time as the more detailed results of the title II probe were available, i.e., as an interim definition of permanent disability. This proposal was sent out for comment and received concurrences from some components. However, others pointed out that these profiles, while a good tool for targeting resources on cases having the greatest pay-off potential, cannot take the place of a definition of permanent disability.

Before we could address ourselves to a synthesis of our two approaches, i.e., a definition of permanent disability together with a use of profiles to select high pay-off potential cases, the current activity aimed at saving more title II disability dollars in FY 1982 and thereafter began. As a result, we have had to move ahead to develop a plan for review of title II cases as soon as possible.

We propose to begin accelerating title II continuing disability reviews using the following plan:

For March and April 1981—Due to systems limitations the best we can do is focus on cases of younger workers (under age 50) and on cases adjudicated in 1973, 1974 and 1975. Both these groups are known to be error prone. When the cases are pulled from files based on an identification by ORS they will be screened against our interim definition of permanent disability (i.e., does the person have one of the conditions listed at tab A?). The remaining cases will be sent to DDS's to be processed in place of the nonrollback conversion cases they are working on currently. We believe ODO can screen out and ship about 45,000 such cases in March and April. (Details appear at tab B.)

For May through September 1981—In May the system will be able to identify title II cases which contain the characteristics reflected in the OA profiles. Those cases will be systems selected, then screened using the same definition of permanent disability mentioned above. The cases selected will be sent to the DDS's, again to be worked in place of nonrollback conversion cases. We believe ODO can screen out and ship about 30,000 such cases per month. (Details appear at tab C. Although the calendar stops with June, phase 2 would be repeated each month to assure necessary case selection.)

This plan spends almost all of our resources on title II cases because of their greater pay-off. We are cognizant, however, that the nonrollback conversion case workload which accounts for 100,000 cases in the budget for FY 1981 is an error-prone workload. We could be subject to criticism at a later date for not having pursued this workload in a more timely fashion. Also, we are expected by Congress to include title XVI cases in our periodic review.

RECOMMENDATION: We recommend that you approve our plan to identify cases for review (through FY 1981) beginning as quickly as possible. Our next step will be to prepare a plan for review of cases in FY 1982. We will also staff out other issues which will need approval such as how to cope with the increased demands on our preeffectuation review resources. We will also prepare a plan for bringing the title XVI cases into periodic review in later years.

DECISION:

Proceed immediately as recommended to process cases for continuing disability review through FY 1981.

APPROVED ____________

DISAPPROVED ____________

OTHER ____________

DATE 3/9/81

NOTE: ODPP TO REVIEW SCREENING CRITERIA DEVELOPED BY OR FOR THE ERROR PRONE PROFILES BEING USED FOR MAY 1981 CDI'S AND BALANCE OF FY81 - TO ASCERTAIN THEIR UTILITY.

## List of Cases Meeting Interim Permanent Disability Criteria

### *Impairments Considered Permanent -- Exclude from Diary*

1. *Amputation of two limbs.*
2. *Amputation of a leg at the hip.*
3. *Amputation of a leg or foot because of diabetes mellitus or peripheral vascular disease.*
4. *Total deafness which was not correctable and was not expected to improve.*
5. *Statutory blindness which was not correctable and was not expected to improve, except cataracts.*
6. *IQ of 59 or less established after the individual's 16th birthday.*
7. *Amputation of a limb in an individual 55 years of age or older at the time of review.*
8. *Neurological impairments allowed as meeting or equalling the listings and not expected to improve.*
9. *Individuals aged 59 years or over who are not otherwise scheduled for diary.*
10. *Individuals aged 55 or over on the basis of meeting or equalling the listings, are of a static or progressive nature, and are not otherwise scheduled for diary.*

## Plan for Accelerating Release of Unscheduled Title II Cases to DDS's
## (Release of Cases Starting in March 1981)

### Conditions and Assumptions

1. That the ORS developed tape of 60,000 selectees will be converted into interpreted punchcard form.

2. That ACID input will be made within a month of release of the cases to permit timely followups.

3. To simplify systems involvement, ORS cases will not be prescreened against case control to determine "files in" condition. Results in larger original draw and additional file search effort on part of ODO.

4. Creates the probability that some profile cases, to be drawn in May, will already be drawn reducing the actual count of "profile" cases to be released.

5. Informing the system that a CDI has been completed on the screened out cases creates somewhat incorrect information on the computer record. This entry to the system is needed to prevent the redrawing of screened out cases on subsequent draws through 1982, until the permanent disability indicator becomes available.

### Actions

I. ORS controls tape containing 1.7 million beneficiaries; developed for 1980-81 CDI Redesign Study.

   A. ORS will run tape and select younger workers (under age 50) who were adjudicated in apparent error-prone years (1973, 1974, 1975) from universe of 201,000 cases.

   B. ORS will rerun subsequent universe to identify potentially selected cases, by State, and see to it that 60,000 cases are selected.

   C. ODS will convert the 60,000 case tape into uninterpreted punchcards.

   D. OCO will convert the uninterpreted punchcards to interpreted punchcards to be used by ODO as case alerts and by ODP for control.

II. ODO will:

   A. Search and retrieve folders.

   B. Screen out and flag "permanently" disabled cases.

C. Test screen for higher cessation incidence cases in some modules. 1/

D. Using preprinted development forms, ship 45,000 cases on a flow basis to DDS's.

E. Segregate control cards by released, permanent and NIF.

F. Input diary information to ACID or provide to OURV for diary input (dependent upon possibility of facilitating input) on the released and permanent cases.

G. Return control cards to ODP for process management.

H. Enter total family benefit amount on flags in cessation cases.

I. Effectuate DDS decisions and send completed flags to ODP.

III. DDS will:

A. Conduct CDI's.

B. Enter special remark on SSA-833.

C. Enter costs on special flag in all cases (for ODP computation of total costs).

D. Return cases to ODO.

IV. ODP will:

A. Provide selection criteria to ORS.

B. Develop and print preprinted development forms, flags and, if needed, SSA-3500 diary slips.

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1/ In our discussion of how to get the most cessation-prone cases to the DDS's, we considered the use of some screen-in criteria recently developed by our Chief Medical Advisor. To find cases meeting these criteria we believe three cases would have to be screened for every one found. Thus, if we wanted to send 30,000 of these higher likelihood of cessation cases to the DDS, ODO would have to screen 105,000 cases (approximately) per month instead of 35,000. Because it does not seem wise to undertake such a lead without having tested the criteria, we have not built into our plan this screen-in for high risk cases. Nonetheless, the approach is too good not to test. Therefore, we propose to try it, perhaps in States which are under hiring freezes and, therefore, may have difficulty handling their share of the monthly allocation. Roughly it would work like this: A State's share of the cases would be pulled of which one-third might meet the screen-in criteria. These would be sent to the DDS. Development of the remaining two-thirds would be undertaken by ODO with only those cases with cessation potential after the development was received being sent on to the DDS.

C. Work directly with ODO modules testing screening in criteria.

D. Manually track cases going to DDS's to assure continued and appropriate flow in pipeline.

E. Work with OMBP and Office of the Actuary to tally costs and savings.

V. RO's will:

A. Assure that DDS's staff up.

B. Monitor and provide technical assistance to DDS's for the continuing disability workload.

## Plan for Releasing 30,000 Title II Cases Per Month to DDS's (Release of Cases Starting in May, 1981)

Actions

I. OS will:

- A. Identify all cases within given profiles by running the RETAP operation.
- B. Run the list identified against case control to select only cases in files.
- C. Run this selected case list into the ACID system to assure timely followups.

II. ODO will:

- A. Search and retrieve folders.
- B. Screen out permanently disabled cases and input them to ACID.
- C. Using preprinted development forms, ship 30,000 cases on a flow basis to DDS's.
- D. Notate family benefit amount on flag in cessation cases.
- E. Effectuate DDS decisions and send completed flags to ODP.

III. DDS will:

- A. Conduct CDI's.
- B. Enter special remark on SSA-833.
- C. Enter costs on flag in all cases (for ODP computation of total costs).
- D. Return cases to ODO.

IV. OOPP will:

- A. Provide selection criteria to OS.
- B. Develop and print development forms.
- C. Manually track cases going to DDS's to assure continued and appropriate flow in pipeline.
- D. Work with OMBP and Office of the Actuary to tally costs and savings.

V. RO's will:

- A. Assure that DDS's staff up.
- B. Monitor and provide technical assistance to DDS's for the continuing disability workload.

## Budget and Staffing Implications

### Background

- DDS budget allocations for FY 1981
  - Regular diaries 152,990
  - Nonrollback conversions 100,000
  - Unscheduled reviews 30,000
- Response to GAO report said we would spend these resources differently.
  - Regular diaries 152,990
  - Nonrollback conversions 50,000
  - Unscheduled title II reviews 80,000
- 55,000 nonrollback conversion cases were shipped to DDS's on 01/28/81.
  - Assumption: 5,000 will have been put into processing by 03/15/81.
- States have been authorized to increase staffing from the FY 1980 level of 9,701 WY to 11,125 WY in FY 1981 and 12,690 WY in FY 1982. (This authorized increase encompasses not only increased CDI's but personalized notices and other added workloads as well.)
- An operating assumption is that cases are processed in 60 days; therefore, the ideal pending should represent about 2-months receipts.

### 30,000 Cases a Month Plan

- Assuming a 10-15 percent screen-out rate 33,000 to 34,500 cases per month would be identified. ODO would screen them down to 30,000 per month and ship them to the DDS's.
- To locate and screen 33,000-34,500 cases per month, ship 30,000 and do the preeffectuation review required for these cases, ODO requires the following workpower:

  315 workyears
  (218 WY in FY 1981 and 97 WY in FY 1982 assuming 60,000 cases will not return to ODO until FY 1982).

315 workyears is equivalent to 554,420 overtime hours (383,680 in FY 1981 and 170,720 in FY 1982). It should be noted that ODO can only work approximately 25,000 hours per week in all operations.

This increase in workyears is essentially unbudgeted. OCO proposes to deal with the increased load through full use of overtime, reduction in the nonmandatory continuance review and the reassessment of other disability examiner workloads for temporary suspension or reassignment to other personnel. Another consideration is to assess temporary workpower readjustment from components outside OCO.

- To process 30,000 title II cases a month DDS's require an additional 545 positions above the current level of staffing devoted to CDI's.

  This workpower will be built up by assigning an additional 1,370 equivalent full-time positions (this includes examiners, clericals and medical consultants) to process CDI loads (see attached).

- To provide front-end medical participation in the preeffectuation review of these cases, MCS physicians require the following workhours: 18,200 hours (12,600 hours in FY 9181 and 5,600 hours in FY 1982). The FY 1981 fee rate is $31.25 an hour. The FY 1982 fee rate, while projected to be $34.25 an hour, may actually reach $38 to $42 an hour. In addition 14,210 clerical hours will be needed.

  This workload is unbudgeted and cannot be assumed without giving up other reviews. We recommend giving up the reliability review, the cessation review and the review of any continuing disability cases the data available to date from the redesign study show to be unproductive. It is doubtful that all of these will result in sufficient workpower to assume all of this additional load.

Attachment

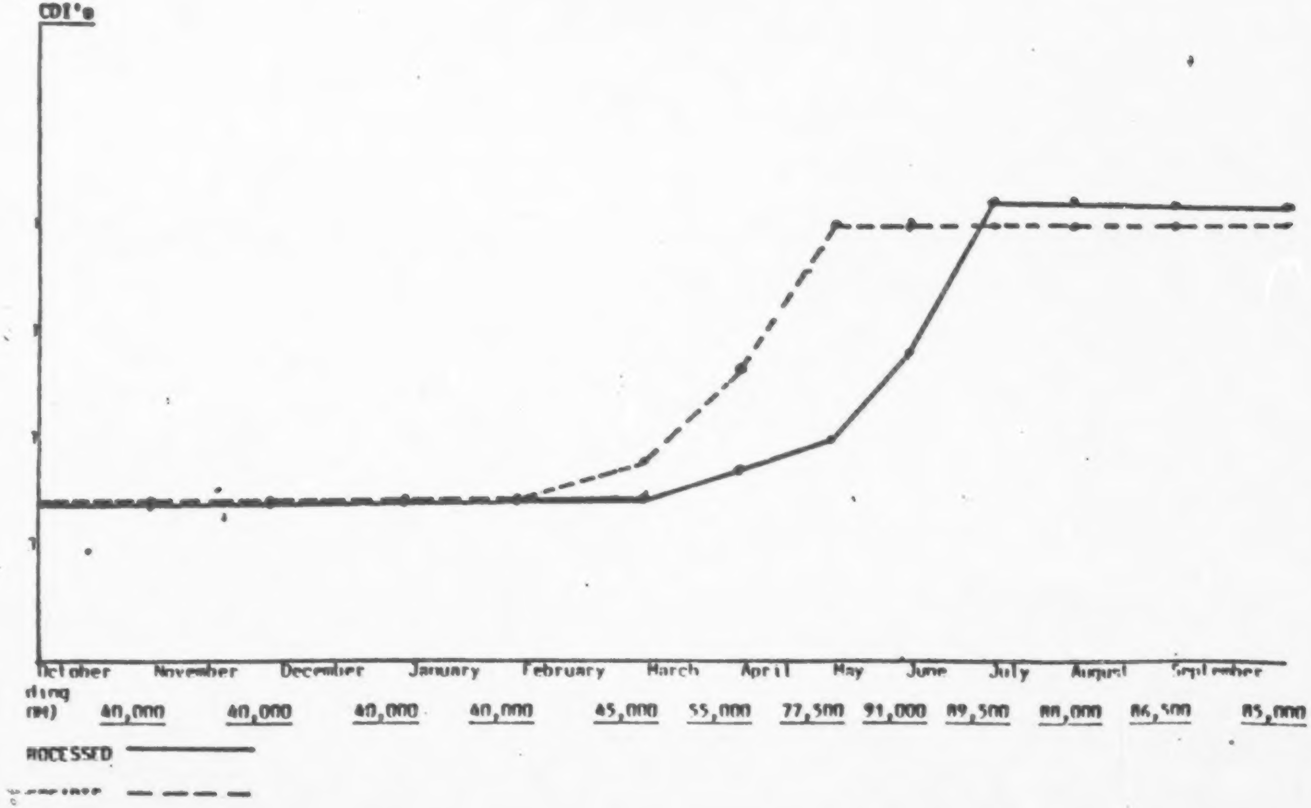
## State Agency Workload Management Plan

30,000 Case Model
Fiscal Year 1981

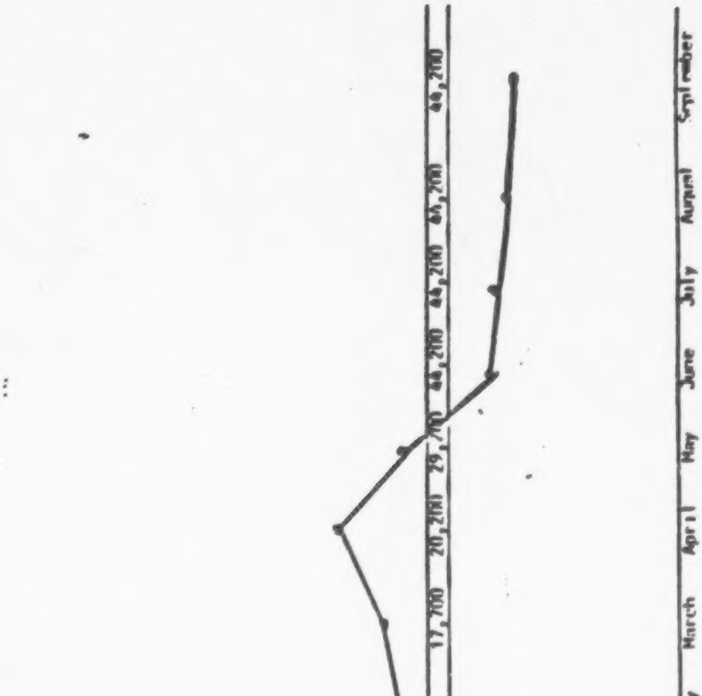
| | Opening Pending | Receipt | Processed | Closing Pending | Equivalent FT Staff | | |
|---|---|---|---|---|---|---|---|
| | | | | | CDI | Other Cases | Total |
| October | 40,000 | 13,700 | 13,700 | 40,000 | 956 | 9,044 | 10,000 |
| November | 40,000 | 13,700 | 13,700 | 40,000 | 956 | 9,044 | 10,000 |
| December | 40,000 | 13,700 | 13,700 | 40,000 | 956 | 9,044 | 10,000 |
| January | 40,000 | 13,700 | 13,700 | 40,000 | 956 | 9,044 | 10,000 |
| February | 40,000 | 18,700 | 13,700 | 45,000 | 956 | 9,044 | 10,000 |
| March | 45,000 | 27,700 | 17,700 | 55,000 | 1,121 | 9,554 | 10,675 |
| April | 55,000 | 42,700 | 20,200 | 77,500 | 1,253 | 10,097 | 11,350 |
| May | 77,500 | 42,700 | 29,200 | 91,000 | 1,537 | 10,488 | 12,025 |
| June | 91,000 | 42,700 | 44,200 | 89,500 | 2,326 | 10,374 | 12,700 |
| July | 89,500 | 42,700 | 44,200 | 88,000 | 2,326 | 10,374 | 12,700 |
| August | 88,000 | 42,700 | 44,200 | 86,500 | 2,326 | 10,374 | 12,700 |
| September | 86,500 | 42,700 | 44,200 | 85,000 | 2,326 | 10,374 | 12,700 |
| | | 357,400 | 312,400 | | | | |

## DI State Agencies CDI Workload Management Plan
Fiscal Year 1981

30,000 Case Model



Weeks Work Pending
30,000 Case Model



2. An overview of the staffing, budgetary, and training changes to accomplish the increase in disability case reviews is given in the memorandum of March 13, 1981, from Fred Schutzman to the regional commissioners. This memorandum was sent to you on May 10 in response to the first set of questions in your letter of April 27. More detailed information is provided on the following charts and tables, which are enclosed:

   1. Disability Determination Services (DDS's) data on staffing and budgets, fiscal years 1979-1983.
   2. Office of Hearings and Appeals (OHA) staff and budgets, fiscal years 1979-1983. Note that the incremental cost associated with increased continuing disability investigations (CDI's) is not available.
   3. Program Operations Manual System (POMS) sections DI 2002 and 2003 which describe the roles of the DDS examiner and physician.
   4. Description of positions in OHA.
   5. DDS review training description by State for CDI examiners.
   6. The SSA recommended training manual for CDI examiners. Note that this manual is not required for use and not every State uses it.
   7. A description of OHA training. Note that this is not specifically directed toward CDI's.

### Disability Determination Services Data

| | FY 1979 | | FY 1980 | | FY 1981 | | FY 1982 (est.)<br>FY 1982-1983 P.B. | | FY 1983 (est.) 5/<br>FY 1982/1983 P.B. | |
|---|---|---|---|---|---|---|---|---|---|---|
| | DDS WY's | DDS $ | DDS WY's | DDS $ | DDS WY's | DDS $ | DDS WY's | DDS $ | DDS WY's | DDS $ |
| DDS Total Administrative Costs | 9,625 | $306,544,000 | 9,701 | $342,547,000 | 10,794 | $434,335,000 | 12,900 | $561,659,000 | 13,590 | $668,790,000 |
| DDS Total CDI Administrative Costs | 915 | $29,053,000 | 952 | $33,088,000 | 1,306 | $54,304,000 | 2,728 | $129,511,000 | 4,203 | $214,223,000 |
| DDS Total Title II CDI Administrative Cost | 587 | $18,871,000 | 635 | $21,896,000 | 918 | $39,072,000 | 2,349 | $113,491,000 | 2,866 | $148,798,000 |
| DDS Total Administrative Cost for Increased Title II CDI's and Ancillary Cases | — | — | 1/<br>44 | 1/<br>$2,065,000 | 2/<br>447 | 2/<br>$20,077,000 | 3/<br>2,203 | 3/<br>$103,135,000 | 4/<br>2,751 | 4/<br>$136,139,000 |
| Title II CDI's | — | — | 43 | $2,042,000 | 401 | $18,401,000 | 1,834 | $88,663,000 | 2,375 | $119,382,000 |
| Ancillary Title II Administrative Costs (e.g., RO considerations, hearings, permanent disability decision) | — | — | 1 | $23,000 | 46 | $1,676,000 | 369 | $14,472,000 | 376 | $16,757,000 |
| Incremental Training WY's (i.e., not base but WY's added/subtracted from training base; included above in Total DDS WY's) | +31 | | -26 | | +390 | | +40 | | 0 | |

1/ Probe/Redesign costs

2/ Probe and unscheduled/accelerated cases

3/ Unscheduled/accelerated cases and, as of 1/82, Periodic Review cases

4/ Periodic Review and ancillary cases from P.R. and unscheduled

5/ Assumes relief from preparing personalized notices and from purchase of Title II Medical Evidence

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## OFFICE OF HEARINGS AND APPEALS
## FULL TIME PERMANENT STAFF ON DUTY
## END OF YEAR

| | FY - 1979 | FY - 1980 | FY - 1981 |
|---|---|---|---|
| **Central Office** | | | |
| A/C Members | 13 | 13 | 14 |
| Hear. & App. Anal. | 249 | 227 | 246 |
| W/L Support | 425 | 384 | 406 |
| Staff Positions | 244 | 238 | 244 |
| Total C/O | 931 | 862 | 910 |
| **Field Offices** | | | |
| ALJ | 639 | 690 | 696 |
| Dec. Writ. | 339 | 410 | 390 |
| Mgm't | 161 | 165 | 246 |
| Hear. Asst. | 828 | 862 | 883 |
| Interp. | 13 | 13 | 13 |
| Clerical | 1,223 | 1,293 | 1,355 |
| Staff Positions | 66 | 66 | 66 |
| Total Field | 3,269 | 3,499 | 3,649 |
| Total OHA | 4,200 | 4,361 | 4,559 |
| Total OHA Cost [1]<br>(in millions) | $123.5 | $135.1 | $157.0 |

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[1] Includes all cost (salaries, benefits, space, equipment, supplies, etc.)

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## OFFICE OF HEARINGS AND APPEALS
## STAFFING PROJECTIONS (END OF YEAR)
## FULL - TIME PERMANENT (ONLY)

| | FY - 1982 | | FY - 1983 | | FY - 1984 | |
|---|---|---|---|---|---|---|
| | Total Positions | CDI Positions | Total Positions | CDI Positions | Total Positions | CDI Positions |
| **Central Office** | | | | | | |
| A/C Members | 15 | 2 | 16 | 4 | 17 | 5 |
| Hear. & Appeals Anal. | 330 | 52 | 441 | 120 | 437 | 122 |
| W/L Support | 479 | 76 | 640 | 174 | 634 | 176 |
| Staff Positions | 282 | - | 287 | - | 287 | - |
| Total Central Off. | 1106 | 130 | 1384 | 298 | 1375 | 303 |
| **Field Offices** | | | | | | |
| ALJ's | 810 | 129 | 810 | 221 | 810 | 225 |
| Dec. Writers | 636 | 101 | 846 | 231 | 846 | 235 |
| Mgm't (HMO) | 135 | 21 | 140 | 38 | 145 | 40 |
| Hear. Asst. | 986 | 157 | 1019 | 278 | 1019 | 283 |
| Interpreters | 13 | 2 | 15 | 4 | 15 | 4 |
| Clerical | 1763 | 280 | 1953 | 532 | 2032 | 565 |
| Staff Positions | 66 | - | 66 | - | 66 | - |
| Total Field | 4409 | 690 | 4849 | 1304 | 4933 | 1352 |
| Total OHA | 5515 | 820 | 6233 | 1602 | 6308 | 1655 |
| Total Estimated OHA Cost[1] ($ millions) | $178.6 | $28.4 | $213.2 | $58.2 | $216.2 | $60.1 |

[1] Includes all cost (salaries, benefits, space, equipment, supplies, etc.)

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## 2001. The DDS Examiner-Physician Team

The determination of disability is a decision requiring team participation by an examiner and a physician, both trained in the disability process. The physician provides expertise in defining the impairment. The examiner determines disability based on the impairment and other nonmedical and vocational factors.

## 2002. DDS Examiner Role

In carrying out the determination team function of DDS Examiner a variety of case processing activities is required which includes but is not limited to the following:

A. Identifying sources of evidence from claim folder information and contacts with claimants, applicants, claimant representatives and other appropriate parties.

B. Sending and following up on letter requests, telephone requests and other forms of communication to get needed medical/vocational evidence.

C. Initiating requests for consultative examinations and following up on these requests to obtain reports as soon as possible.

D. Consulting with physicians to resolve medical issue and evidence interpretations.

E. Consulting with physicians and other staff members to resolve problems in getting evidence from attending physicians, hospitals, consultative examiners, etc.

F. Assessing the significance of residual functional capacity, age, education and work experience on the ability to engage in SGA.

G. Preparing determinations including regulation coding and decision rationales, and signing determinations.

H. Recording case data for operations reporting, case control and ARS inputs.

I. Preparing vocational rehabilitation referrals.

## 2003. DDS Physician Role

In carrying out the determination team function of DDS Physician a variety of professional medical activities is required including, but not limited to the following:

A. Evaluating medical evidence to determine its adequacy for making disability decisions.

B. Assessing the severity of impairments and describing the functional capacities or limitations imposed by impairments.

C. Reviewing requests for consultative examinations in specific claims to assure that CE's are necessary and will resolve the issues as intended.

D. Describing alternatives when concurrence is not given for CE's and determinations.

E. Evaluating medical questions and making recommendations for improvement on letters and other forms of communication designed to obtain proper evidence.

F. Discussing with examiners and other staff members ways to resolve problems in getting evidence of record.

G. Discussing with staff members ways to improve relations with the medical profession, enlarge consultative examiner panels and minimize CE processing time.

H. Discussing with training staff ways to improve examiner understanding and use of medical evidence

I. Reviewing consultative reports for deficiencies in content and recommending ways to avoid deficient reports.

J. Reviewing determinations to assure integrity of decisions based on medical evidence, and signing determinations.

## Office of Hearings and Appeals
## Brief Position Descriptions

### Central Office:

Appeals Council Member: Reviews and makes final decision of all request for review. Also takes own motion review on selected hearing decisions.

Hearings and Appeals Analyst: Reviews and writes decisions for approval by the Appeals Council Members.

Workload Support: These positions include all supervisors in the workload areas, clerk typist, mail and messenger, docket and files etc.

Staff Positions: Includes all administrative positions such as Executive staff, Personnel, Financial Management etc.

### Field Offices:

Administrative Law Judges: Presides over hearings and makes final decision on all request of hearing cases.

Decision writers: Drafts and recommends hearing decisions for approval by the administrative law judge.

Management Positions: Coordinate the flow of workload within the hearing office and assists in the supervisory and administrative duties within the hearing office.

Hearing Assistant: Assists in conducting hearing, schedules hearings, informs all participants of date and time of hearing and review cases to insure all necessary information is in file.

Interpreters: Translates at hearings and transcribes written information into English.

Clerical: Types all draft and final decisions, enters information necessary for the case control file system, filing etc.

Staff Positions: All administrative duties for their respective region.

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## DDS CDI Review Training for Examiners

| UNITED STATES | | Training Requirements and Schedules 3/81 - 4/82 | Future Training |
|---|---|---|---|
| Boston | Connecticut | OJT 1/ | Supervisory checks, and high-risk reviews |
| | Maine | OJT | |
| | Massachusetts | 80 hours training | " |
| | New Hampshire | OJT | " |
| | Rhode Island | OJT | " |
| | Vermont | OJT | " |
| New York | New Jersey | Weekly OJT | Weekly as needed OJT |
| | New York | OJT | Refresher as needed |
| | Puerto Rico | Weekly OJT | Weekly as needed OJT |
| Philadelphia | Delaware | 16-24 hours training; OJT | As needed; train new promotions |
| | District of Columbia | " | |
| | Maryland | " | " |
| | Pennsylvania | " | " |
| | Virginia | " | " |
| | West Virginia | " | " |
| Atlanta | Alabama | 6 hrs. training; 6 hrs. OJT; newhires=8 wks. trng | OJT as needed |
| | Florida | 8 hrs. orientation; 40 hrs. OJT | OJT as needed |
| | Georgia | 9 hours refresher | 9 hrs. quarterly |
| | Kentucky | 2 weeks training | monthly/quarterly/refresh |
| | Mississippi | OJT only; review by experienced examiners | OJT only |
| | North Carolina | 4 days for new promotions | None |
| | South Carolina VR | 8 weeks for new promotions | as needed - refresher |
| | Blind | | |
| | Tennessee | 6 hours training; OJT | as needed - refresher |
| Chicago | Illinois | General OJT | OJT when needed |
| | Indiana | 5-8 hours training | being developed now |
| | Michigan | General OJT | refreshers as needed |
| | Minnesota | General session for all; 4 hrs. each quarter | None |
| | Ohio | 20 hours training | being developed now |
| | Wisconsin | 4 hours | as needed |
| Dallas | Arkansas | OJT | as needed |
| | Louisiana | OJT | " |
| | New Mexico | OJT | " |
| | Oklahoma | 6 hours training | " |
| | Texas | 80 hours training | " |
| Kansas City | Iowa | General OJT | as needed |
| | Kansas | 40 hours each quarter | as needed |
| | Missouri | 4-8 hours OJT | refresher as needed |
| | Nebraska | 32 hours OJT | as needed |
| Denver | Colorado | General OJT | as needed |
| | Montana | " | refresher as needed |
| | North Dakota | " | refresher as needed |
| | South Dakota | " | as needed |
| | Utah | " | refresher as needed |
| | Wyoming | " | refresher as needed |
| San Francisco | Arizona | None | as needed |
| | California | General training for new promotions | as needed |
| | Guam | | |
| | Hawaii | None | as needed |
| | Nevada | 8 hours | as needed |
| Seattle | Alaska | OJT; refresher sessions | staff meetings as needed |
| | Idaho | " " | refresher as needed |
| | Oregon | " " | |
| | Washington | " " | |

1/ OJT = on-the-job training

## Training in the Office of Hearings and Appeals

In October 1981 the Office of Hearings and Appeals (OHA) established a Field Training Initiative Staff to develop new and expanded training programs for all OHA field personnel. The orientation programs for new administrative law judges (ALJ's) was revised and expanded to 6 weeks to include more intensive training in disability adjudication.

Beginning in May 1982 a series of refresher training sessions will be held with the entire corps of ALJ's. We anticipate that all ALJ's will have participated in this program by May 1983. The major focus of this training will be in the area of adjudicative differences that exist between OHA decisionmakers and the State agencies. We expect to achieve a better understanding of the adjudicatory standards governing all decisionmaking which will result in greater consistency and accuracy at the various adjudicatory levels.

A 2-week initial training package for staff attorneys and hearing analysts has also been developed. These individuals draft the decisions for the ALJ's. Approximately 185 new decision writers will be trained by the end of June 1982. Subsequently, the course will be required of all new decision writers during their first 3 months of duty. In addition, a 3-day refresher course for existing decision writers is being developed. It is anticipated all decision writers will have received this training prior to the end of the fiscal year 1983. A training program for the remainder of field support staff (primarily clerical) is scheduled for implementation of July 1982. This is a program on continuous onsite training. The primary emphasis is procedural rather than substantive.

In order to strengthen the overall management of the OHA hearing office system, a 4-day management training program has been developed for ALJ's in charge and hearing office managers. The material training sessions have been scheduled for prior to the end of November 1982 to cover the entire group of over 250 field managers.

In the future it is OHA's objective to provide refresher training to one-half of all ALJ's, decision writers and field managers every year. The field support staff training is continuous and ongoing.

3. Data are presented below for the period March 1981, through March 1982, in response to questions 3(a), (b), (c), and (d). The data requested in questions 3(e) and (f) are not available. It should be noted that the data shown refer to all CDI's, including medical diaries, and are not limited to periodic review cases.

Number of Cases 1/

| Month | Sent to DDS For Review | Reviewed By DDS 2/ | Reviewed With Consultative Exam | Reviewed and Terminated |
|---|---|---|---|---|
| 1981 | | | | |
| March | 14,040 | 10,597 | 5,575 | 4,543 |
| April | 34,578 | 11,443 | 4,949 | 4,230 |
| May | 33,639 | 19,398 | 8,201 | 6,500 |
| June | 31,013 | 21,354 | 11,256 | 8,707 |
| July | 44,752 | 28,281 | 15,442 | 12,153 |
| August | 40,557 | 26,131 | 13,942 | 11,042 |
| September | 56,683 | 28,005 | 15,103 | 11,542 |
| October | 21,419 | 31,803 | 17,777 | 12,435 |
| November | 21,242 | 29,490 | 17,437 | 11,846 |
| December | 39,236 | 35,751 | 21,682 | 15,290 |
| 1982 | | | | |
| January | 28,478 | 29,929 | 17,071 | 13,410 |
| February | 49,653 | 30,605 | 16,930 | 12,715 |
| March | 71,693 | 40,328 | 21,140 | 13,836 |
| 13-month Total | 487,083 | 343,115 | 186,505 | 138,249 |

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1/ Includes title II and titles II/XVI concurrent cases.
2/ All decisions, including "no decision" cases.

(4a) Question: SSA indicated that in 1980 a national review of 25,000 Title II disability cases was instituted to identify typical beneficiaries most likely to be found ineligible. What were the results and conclusions of that review? What types of beneficiaries were found to be ineligible, and on what specific criteria was that finding based? How are the findings of this national study used in selecting cases for review?

Answer: The study of 25,000 Title II cases was initiated in April 1980. The study universe represented 60 percent of all disabled beneficiaries. Excluded from the study universe were beneficiaries over age 62, beneficiaries entitled before 1970, beneficiaries entitled after 1978, and all disabled widows and children. The study found that 33 percent of the beneficiaries in the study universe no longer met the requirements of the law. The criteria and procedure for determining eligibility were the established continuing disability review procedures; that is, the cases were adjudicated by the State disability determination services using the current medical and vocational listings in the Code of Federal Regulations.

The study found that the beneficiaries most likely to be determined ineligible:

--have auxiliary beneficiaries,

--were between age 31 and 55,

--were initially entitled between 1973 and 1976 inclusive,

--were receiving worker's compensation,

--were initially denied but were determined to be disabled upon reconsideration or by an Administrative Law Judge (ALJ),

--were receiving less than $200 or more than $599 total monthly benefits.

These study data are to be used in selecting periodic review cases in 1982. (See answer 4c.)

(4b) Question: Similarly, the SSA stated that it had completed a review of 3,000 Title II disabled beneficiaries to determine payment error rate and to permit profiling of high-risk cases. Please provide a copy of the results of that review, including specific characteristics, and its uses since it was developed.

Answer: In 1979 and 1980, SSA conducted a study of 3,154 cases randomly selected from the universe of disabled worker beneficiaries receiving benefits for April 1979. The study revealed that 18.3 percent of the benefit payments for April 1979 should not have been paid since the disabled beneficiary did not meet the requirements of the law.

By analyzing select characteristics for all study cases (e.g., current age, date of entitlement, age at filing), we were able to determine the characteristics of people most likely to not be entitled to disability benefit payments. The results of this analysis, called profiling, were used to select the most error-prone cases for periodic review in 1981.

The ten profiles of error-prone cases used for case selection in 1981 were:

(1) Total benefit payments over $600, disabled beneficiary under age 49, entitled prior to 1976, less than five beneficiaries receiving benefits on the account;

(2) Total benefit payments greater than $400, disabled beneficiary age 40-49, date of entitlement after 1975;

(3) Total benefit greater than $600, disabled beneficiary under age 49, date of entitlement prior to 1976, more than four beneficiaries receiving benefits on the account;

(4) Total benefit greater than $400 but less than $600, disabled beneficiary under age 49, date of entitlement prior to 1976;

(5) Total benefits greater than $200 but less than $400, disabled beneficiary under age 49 and age 30-49 at time of initial filing, not in custodial care, and no children receiving benefits on the account;

(6) Total benefits greater than $400, disabled beneficiary aged 50 to 59, date of entitlement after 1970;

(7) Total benefits greater than $400, disabled beneficiary under age 49, worker and children or worker and disabled wife receiving benefits on the account;

(8) Total benefits greater than $400, disabled beneficiary under age 39, date of entitlement after 1975;

(9) Total benefits greater than $200 but less than $400, disabled beneficiary under age 49, not in custodial care, and age 30 to 49 at time of filing;

(10) Total benefits greater than $400, disabled beneficiary age 50 to 59, date of entitlement prior to 1969.

(4c) Question: At the same time, the SSA noted the need to better identify high-dollar error in Title II cases and had developed case profiles to accomplish that. Please provide a copy of those profiles and an explanation of the specific criteria for their development.

Answer: The profiles developed for 1981, based on the review of 3,154 cases, identified sufficient error-prone cases to permit the continued use of the profiles into 1982. Selection of error-prone cases for the remainder of 1982 will be based on a profile analysis of the 25,000 case sample and will entail a manual screening against a list of characteristics of permanent disabilities.

Unlike the profiling mechanism employed in 1981, the analytical technique to be used to select error-prone cases for the remainder of 1982 does not produce "profile" characteristics of cases. Rather, the new "profiling" technique assigns a specific numeric value to each case representing probability of each case resulting in a cessation of benefits. This "profiling" formula considers both the probability of cessation and the total benefit dollars involved in the case. In general, the cases selected for review later in 1982 will be those with the same characteristics as those cases found ineligible during the 25,000 case study (see response to question 4a).

5. The specific criteria for selecting cases are described in the response to question 4(b). The following table presents the number of cases selected using various combinations of profiles for the period 1981 through April 1982. The profile numbers refer to the list given in response to question 4(b).

| Profile Selected | | Total Cases Selected 1/ |
|---|---|---|
| 2, 5, 9 | | 183,484 |
| 4, 7, 8 | | 147,454 |
| 6, 10 | | 180,165 |
| 1, 3 | | 25,918 |
| | Grand Total | 537,021 |

NOTE: In addition, 115,028 cases were selected for review from the universe of cases established under the 1980-1981 CDI Redesign Study. The basis for selecting from this universe were: 1) entitlement in the years 1973 through 1975 and 2) under age 50 at the time of selection.

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1/ While this breakdown provides numbers of cases selected by profile, it does not reflect actual release of cases for CDI. After computer selection is made some cases are found to be "not in file" during selection month; cases are determined to be not subject to review because of intervening events, such as recently completed CDI not posted to computer record, recent death, previous termination action not acted on. In addition, cases are screened to determine whether they meet the criteria for permanent disability. These several factors were taken into consideration in designing the initial monthly selection counts. As a result of all screening actions, actual release of cases for CDI represent approximately 50 percent of the cases selected by monthly profile counts. No breakdown is available of actual profile CDI releases.

6. The requested data are not available separately for CDI cases.

7. The enclosed table presents data on administrative law judge (ALJ) reversal rates for fiscal years 1972-1982. Unfortunately, the data includes all ALJ decisions and cannot be separated into initial decisions and CDI's.

Disability and Non-Disability Reversal Rates 1/
FY 1972 - FY 1982

| | DISABILITY | | | | | | | | NON-DISABILITY | | | | | | | | | | | | TOTAL ALL PROGRAMS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TITLE II DISABILITY | | TITLE XVI - SSI 3/ | | TITLE II/ XVI SSI 3/ | | TOTAL | | TITLE II RSI | | TITLE XVIII HI | | TITLE IV BL | | TITLE XVI SSI AGED | | TITLE II/XVI SSI AGED | | TOTAL | | | |
| | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | | Rev Rate to | |
| Fiscal Year | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. | DEC. | DISP. |
| 1972 | 48.9 | 44.2 | NA | NA | NA | NA | 48.9 | 44.2 | 31.4 | 26.3 | 41.8 | 35.6 | 10.3 | 9.8 | NA | NA | NA | NA | 23.6 | 21.2 | 42.7 | 38.6 |
| 1973 | 50.9 | 45.9 | NA | NA | NA | NA | 50.9 | 45.9 | 34.4 | 28.8 | 47.6 | 42.2 | 92.7 | 76.4 | NA | NA | NA | NA | 54.4 | 46.7 | 51.5 | 46.0 |
| 1974 | 52.4 | 47.6 | NA | NA | NA | NA | 52.4 | 47.5 | 39.0 | 33.8 | 50.0 | 50.0 | 18.2 | 16.7 | NA | NA | NA | NA | 28.0 | 26.1 | 45.9 | 41.6 |
| 1975 | 54.3 | 49.1 | 51.5 | 42.3 | 58.3 | 51.2 | 54.3 | 48.4 | 39.2 | 33.7 | 50.0 | 49.6 | 23.6 | 22.3 | 30.7 | 33.0 | - | - | 26.6 | 24.0 | 46.5 | 41.9 |
| 1976 2/ | 52.2 | 46.0 | 53.2 | 44.7 | 52.3 | 45.4 | 52.5 | 45.6 | 40.5 | 34.4 | 47.7 | 40.6 | 29.5 | 28.4 | 47.3 | 43.0 | 66.7 | 66.7 | 31.4 | 29.7 | 48.4 | 42.7 |
| 1977 | 54.9 | 48.6 | 53.1 | 45.1 | 53.1 | 46.6 | 54.1 | 47.4 | 40.3 | 34.3 | 51.8 | 43.1 | 44.1 | 40.1 | 59.0 | 52.6 | 55.6 | 35.7 | 46.2 | 40.0 | 53.6 | 47.0 |
| 1978 | 57.7 | 52.3 | 53.8 | 46.6 | 54.3 | 48.5 | 55.9 | 50.0 | 39.0 | 33.9 | 39.4 | 31.5 | 41.1 | 37.1 | 58.1 | 50.6 | 27.3 | 23.1 | 42.4 | 38.2 | 55.3 | 49.3 |
| 1979 | 61.4 | 56.7 | 57.2 | 50.3 | 57.7 | 52.6 | 59.5 | 54.1 | 38.2 | 32.7 | 32.5 | 26.7 | 35.3 | 31.5 | 59.6 | 51.7 | 75.0 | 56.3 | 38.8 | 32.0 | 58.5 | 53.0 |
| 1980 | 65.0 | 60.0 | 58.6 | 51.2 | 60.9 | 55.0 | 62.5 | 56.6 | 40.9 | 34.7 | 44.5 | 35.1 | 47.1 | 40.3 | 62.2 | 53.5 | 50.0 | 40.0 | 44.5 | 37.0 | 61.0 | 55.0 |
| 1981 | 65.3 | 59.9 | 57.0 | 49.0 | 59.5 | 53.5 | 61.9 | 55.9 | 40.1 | 33.0 | 43.3 | 33.7 | 39.0 | 33.5 | 55.7 | 45.7 | 73.3 | 55.0 | 42.7 | 34.7 | 61.3 | 55.2 |
| 1982 4/ | 62.9 | 57.7 | 54.2 | 47.1 | 56.6 | 50.9 | 59.5 | 53.7 | 36.6 | 29.9 | 39.7 | 28.0 | 34.3 | 28.2 | 49.5 | 39.9 | 54.5 | 50.0 | 38.9 | 30.5 | 58.9 | 52.9 |

1/ Includes initial applications as well as terminations and CDIs.
2/ Does not include transition quarter.
3/ Includes SSI Blind cases.
4/ Through March 31, 1982; does not include quarterly adjustment.
NA = Not Applicable. Only 121 SSI Cases were processed during FY 1974; breakout of title XVI and concurrent title II/XVI workload not available.

8. The regulations governing DDS reimbursement rates for consultative examinations (CE's) are given in 46 FR 404.1624 (copy enclosed). The average payment for a case in which a CE was purchased was $159.27 in the fourth quarter of calendar year 1981.

The requirements for CE's were recently issued as Social Security Ruling No. 82-14. A copy of that ruling is enclosed.

In regard to the GAO report of October 1979, P.L. 96-265 section 304, effective June 1, 1981, altered SSA's relationship with the States. Under the regulations implementing the law, the States must provide a quality assurance (QA) function. However, the internal design, specific requirements, and staffing for the QA function are not prescribed. The basic objective of the new regulations is to regulate only to the extent necessary to ensure effective and uniform administration of the disability program.

Thus, the States have control over management of their operation as long as performance is acceptable. Performance standards prescribed target (an optimum) and threshold (minimum) levels of accuracy and promptness of disability decisions. SSA may impose specific requirements on the DDS, i.e., in terms of their QA function, only if performance standards are not met. Accordingly, SSA is not able to mandate that State agencies conduct special studies unless their performance is not acceptable under the regulations.

However, in line with our constant efforts to improve the medical examination process, we have initiated a wide range of actions designed to furnish useful guidelines and establish an effective oversight and monitoring system, particularly with regard to consultative examinations (CE). A brief summary follows.

- Basic SSA policy statement s and instructions have been issued in (1) a Social Security ruling, (2) SSA Program Operations Manual System distributed to all State agency program personnel and all SSA program and policy personnel who have responsibilities in the disability program, and (3) a SSA program policy statement.
- SSA has completed the initial monitoring of the State agency CE management process enabling the regional commissioners to direct their oversight efforts at the weaknesses disclosed.
- The second stage of SSA monitoring efforts is now under way based on a protocol for reviewing all aspects of the CE providers' operation and the DDS oversight of it. Joint SSA-DDS onsite reviews of 30 providers are now in progress.

- State agency administrators have recently attended a disability program management forum which included workshops designed to provide the opportunity to share problems and solutions to problems in the CE process.

- We are currently assessing how aggressively the DDS's are obtaining medical evidence of record.

Our plans for the future include producing issuances to accommodate developments and meet contingencies as they arise. These include:

- Administrative guidelines to State agencies for oversight of provider activities and instructions to regional commissioners for monitoring State agency compliance with those guidelines.

- Technical policy guidelines covering the effect of various laws and regulations on CE providers.

- Development of methods of review of CE provider activities as the need becomes evident.

standards in the selection, tenure, and compensation of any individual employed in the disability program.

(c) *Travel.* The State will make personnel available to attend meetings or workshops as may be sponsored or approved by us for furthering the purposes of the disability program.

(d) *Restrictions.* Subject to appropriate Federal funding, the State will, to the best of its ability, facilitate the processing of disability claims by avoiding personnel freezes, restrictions against overtime work, or curtailment of facilities or activities.

### § 404.1622 Training.

The State will insure that all employees have an acceptable level of competence. We will provide training and other instructional materials to facilitate basic and advanced technical proficiency of disability staff in order to insure uniformity and effectiveness in the administration of the disability program. We will conduct or specify training, as appropriate, but only if:

(a) a State agency's performance approaches unacceptable levels; or

(b) the material required for the training is complex or the capacity of the State to deliver the training is in doubt and uniformity of the training is essential.

### § 404.1623 Facilities.

(a) *Space, equipment, supplies, and other services.* Subject to appropriate Federal funding, the State will provide adequate space, equipment, supplies, and other services to facilitate making accurate and prompt disability determinations.

(b) *Location of facilities.* Subject to appropriate Federal funding, the State will determine the location where the disability determination function is to be performed so that disability determinations are made accurately and promptly.

(c) *Access.* The State will permit us access to the premises where the disability determination function is performed for the purposes of inspecting the work and activities required by the regulations and assuring compliance with pertinent Federal statutes and regulations. We will contact the State and give reasonable prior notice of the times and purposes of any visit.

### § 404.1624 Medical and other purchased services.

The State will determine the rates of payment to be used for purchasing medical or other services necessary to make determinations of disability. The rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service. The State will maintain documentation to support the rates of payment it uses.

### § 404.1625 Records and reports.

(a) The State will establish and maintain the records and furnish the schedules, financial, cost, and other reports relating to the administration of the disability programs as we may require.

(b) The State will permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the work which the State performs under these regulations. These records will be retained by the State for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR Parts 1–30).

### § 404.1626 Fiscal.

(a) We will give the State funds, in advance or by way of reimbursement, for necessary costs in making disability determinations under these regulations. Necessary costs mean direct as well as indirect costs as defined in title 41 CFR subpart 1–15.7 and in Federal Management Circular 74–4, as amended or superseded.

(b) The State will submit estimates of anticipated costs in the form of a budget at the time and in the manner we require.

(c) We will notify the State of the amount which will be made available to it as well as what anticipated costs are being approved.

(d) The State may not incur or make expenditures for items of cost not approved by us or in excess of the amount we make available to the State.

(e) After the close of a period for which funds have been made available to the State, the State will submit a report of its actual expenditures. We will give the State an audit report showing whether the expenditures were consistent with cost principles described in subpart 1–15.7 of part 1–15 of the Federal Procurement Regulations (41 CFR 1–15.7) and in written guidelines in effect at the time the expenditures were made or incurred.

(f) Any monies paid to the State which are used for purposes not within the scope of these regulations will be paid back to the Treasury of the United States.

### § 404.1627 Audits.

As soon as practicable after the close of each budgetary period, or at other times as necessary, the books of account and records in each State pertaining to the administration of the disability program under the Act will be audited by our Inspector General's office. These audits are conducted to determine whether the expenditures were made for the purposes intended and in amounts necessary for the proper and efficient administration of the disability program. Audits will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit.

(a) *Questioned items.* Expenditures of State agencies will be audited on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any questioned items. They will be given reasonable time to explain questioned items or expenditures. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on questioned items in the audit report.

(b) *State appeal of audit determinations.* The appropriate SSA regional commissioner will notify the State of his or her determination on the audit report. If the State disagrees with that determination, the State may request reconsideration in writing within 30 days of the date of the regional commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Operational Policy and Procedures, to the Commissioner of Social Security, Room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. The Commissioner will make a determination and notify the State of that decision in writing no later than 45 days from the date of the State's appeal. The decision by the Commissioner will be final and conclusive upon the State unless the State appeals that decision in writing to the Department of Health and Human Services, Departmental Grant Appeals Board within 30 days after receiving the Commissioner's decision. See § 404.1683.

### § 404.1628 Property.

The State will have title to equipment purchased for disability program purposes. The State will be responsible for maintaining all property it acquires or which we furnish to it for performing the disability determination function. The State will identify the equipment by labeling and by inventory and will exists to support the administrative law judge's action, and stated findings and conclusions. This requires that the decision be based on sufficient quantity and quality of evidence so that a reasonable mind might come to the same conclusion.

In addition, the Appeals Council will review a hearing decision where there is a *broad* policy or procedural issue that may affect the general public interest. Review for this reason will generally be limited to circumstances in which a decision raises or addresses a question which has potentially far-reaching applicability for a *significant* number of claims.

The Appeals Council will not ordinarily review a hearing decision where the end result would remain unchanged unless there is a compelling need to do so.

Nothing in this Program Policy Statement alters or affects the Appeals Council's authority to reopen a decision under the rules set forth in regulations sections 404.988 and 416.1488. Under these regulations, the Appeals Council may reopen for any reason any decision within 12 months of the date of the notice of the initial determination. After 12 months, the Appeals Council may reopen a decision for such reasons as specified in the regulations.

The procedures and instructions for staff which provide support to the Appeals Council in performing its review functions are contained in staff manuals.

**EFFECTIVE DATE:** The ongoing program of comprehensive evaluation of administrative law judge actions within OHA commenced effective October 1, 1981.

**CROSS-REFERENCES:** Claims Manual sections 7166.4 and 13691.5.

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**(To be Published as PPS-63)** **SSR 82-14**

## TITLE II AND TITLE XVI: REQUIREMENTS FOR CONSULTATIVE EXAMINATIONS AND TESTS PURCHASED IN CLAIMS BASED ON DISABILITY

**PURPOSE:** To state the policy on consultative examinations purchased at Federal Government expense in disability claims filed under the Social Security (title II) and Supplemental Security Income (title XVI) Programs.

**CITATIONS (AUTHORITY):** Sections 223(d)(5) and 1633 of the Social Security Act; regulations Nos. 4 and 16, sections 404.1513, 404.1517, 416.913 and 416.917.

**PERTINENT HISTORY:** Section 223(d)(5) of the Social Security Act provides, in pertinent part, that an individual shall not be considered to be under a disability unless he or she furnishes such medical and other evidence as the Secretary may require. Under implementing regulations (20 CFR sections 404.1512-404.1518 and 416.912-416.918), determinations as to disability are based on evidence supplied by the claimant's own medical sources and, where needed, on independent physical or mental examinations or tests purchased at Federal Government expense. Such examinations, referred to as "consultative examinations (CE's)," may be needed in order to: (1) to obtain more detailed medical findings about the claimant's impairments; (2) obtain technical or specialized medical information; or (3) resolve conflicts or differences in medical findings in the evidence already in file.

The regulations, as well as disability operating instructions, clearly intend that evidence obtained as a *result* of purchased examinations or tests will permit sound adjudication to be made when such evidence is considered along with all other medical and nonmedical evidence submitted in connection with a disability claim. To constitute evidence acceptable for adjudicative purposes, the CE must be performed by a competent physician,[1] and the report must be complete and personally reviewed and signed by the individual who actually performs the examination and/or tests.

**POLICY STATEMENT:** Consultative examinations and tests purchased in connection with the adjudication of title II and title XVI disability claims must be performed by qualified sources. Those sources and the reports they furnish must reflect the following essential characteristics:

1. **Physician Qualifications**—The physician doing the examination or test must be competent to do so. While the Social Security Administration (SSA) does not require that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that he or she is licensed and, in the judgment of the Disability Determination Services (DDS), has the training and experience to perform the type of examination or test requested. The physician's professional conduct and reputation must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the program.
2. **Physician Independence**—All implications of possible conflicts of interest must be avoided. For example, the physician doing the examination or test must not be a full-time or part-time employee of a State DDS or any component of SSA unless there is no other qualified medical resource available. In such instances, the physician cannot participate in the disability decisionmaking or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.
3. **Report Content**—The reported results of the history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a

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[1] It is recognized that CE's will occasionally be performed by specialists other than physicians such as psychologists, audiologists, etc. In such situations, the guidelines spelled out in this PPS are applicable to the extent possible.

complete and competent examination. SSA recognizes that the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. Thus, the extent and detail of information expected in a report of a general internal medicine examination will differ from that expected when a neurological, orthopedic, psychiatric, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination evidence relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. When a complete examination is involved, the report should include:

a. The major or chief complaint(s) of the claimant.
b. Within the area of specialty of the examination, a detailed description of the history of the major complaint(s).
c. A description, and disposition, of pertinent "positive," as well as "negative," detailed findings based on the history, examination and laboratory tests related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.
d. The results of requested laboratory tests performed according to the requirements stated in the Listing of Impairments (see Regulations Nos. 4 and 16; appendix 1); and the results of other tests (e.g., X-rays of the most involved arthritic joint) that are found necesary as a result of the physician's examination. (Such tests require DDS physician authorization.)
e. Diagnosis and prognosis.
f. A medical assessment (except in statutory blindness claims and disability claims for widows and widowers) which shows the claimant's ability to do work-related activities or to function in a work setting.

In addition to the above, the consultative physician must consider, and provide some explanation or comment on, the major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions must represent the information provided by the physician who signs the report.

4. **Physician Signature**—The physician actually performing the consultative examination or testing must personally review and sign the report; the signature of any other physician or person is not acceptable. This attests to the fact that the physician doing the examination or testing is solely

responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory tests results.[3]

**EFFECTIVE DATE:** This policy is *effective* upon receipt.-

**CROSS REFERENCES:** Program Operations Manual System, part 4, sections DI 2026.B., 2027-2028.

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[3] In some instances, a medical technician or other paraprofessional will contribute to the information (e.g., x-rays or laboratory findings) contained in a medical report. In such cases, the physician signing the report must verify the reported findings and conclusions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administratic
Chicago Regional Office

## Memorandun

Date : JAN 25 1982

Refer To : SD5B4

To : Office of Operational Policy and Procedures

From : Office of the Regional Commissioner

Subject : Evaluation of Residual Functional Capacity (RFC) in Psychiatric impairments--INFORMATION

The evaluation of psychiatric impairments which fall short of the listings is a continued problem in this region and, apparently, nationally. In our May 27, 1981 memorandum, we inquired about the instructions pertaining to the evaluation of RFC in mental impairments. Our concern was that while Informational Digest Item Part Two, C4.02A indicates that the younger worker with a severe mental impairment which falls short of the listings will generally retain the RFC for at least unskilled work, communications and returns indicated that in practice there are no exceptions in cases involving younger workers. Your response of August 3, 1981, similarly reinforces our observations in that the sole example of an exception pertained to a worker approaching retirement age.

Subsequent to our last communication, thousands of profile CDI's are being and have been processed by our DDS'. These include large numbers of claims with psychiatric impairments which do not meet the medical listings. We have advised our DDS' to approach the evaluation of RFC in these cases in the manner consistent with the communication and feedback to date. As a result, large numbers of cessations are being made and widespread public reactions have surfaced.

Your August 3 memorandum advised that action was being taken to clarify or replace Informational Digest, Part Two, No. C4.02A, and that you are attempting to develop RFC examples for mental impairments. We strongly urge that these activities be completed as quickly as possible in order to clarify this subject.

In order to provide you with background on the reactions to this subject we have enclosed a letter from the Wisconsin DDS (Attachment 1) which provides first hand reactions from the DDS management and staff. Other DDS' in the region have likewise expressed concerns about the large numbers of severely impaired claimants who are younger workers with mental impairments and who are currently being denied or benefits are being ceased.

The medical community, treating and consulting psychiatrists and community mental health centers, have expressed concern about the cessation of benefits for patients whom they consider to be severely impaired and incapable of resuming work activity. This reaction by the various components of our mental health system is frequently similar to the viewpoint recently expressed in a letter published in the November 20, 1981, edition of the Psychiatric News, a publication of the American Psychiatric Association (Attachment 2).

One Area Director, Field Operations, has provided feedback regarding field office employee reaction to some of the medical cessations involving beneficiaries with psychiatric impairments. He indicated that in some instances, the field offices are concerned that individuals whom they consider to be "obviously" disabled, based upon observed bizarre and unusual behavior and interviews at the SSA District Offices, are denied. The DO network has suggested a study whereby they observe and interview individuals who have mental impairments and are about to be medically ceased. While we have reservations about the study proposed, we do appreciate the concerns expressed by the DO and acknowledge that they are more than isolated reactions. The voluntary assumption of added work duties by the DO or Area Director is not ordinarily offered without due consideration.

We have encountered serious reactions from beneficiaries themselves. There have been several suicides in this region following Title II cessations and there have been other suicide threats and attempts, and threats to DDS employees and CE physicians from beneficiaries with mental impairments.

There has been reaction by the press and the general public regarding disability claimants and beneficiaries with mental impairments. The New York recently published an article regarding the growing number of homeless people in New York City (Attachment 3). While the article clearly indicates that there are other reasons for "street people" than mental illness, it nonetheless is of interest to us from one standpoint. The article contains brief profiles of several individuals, one who is reportedly on SSI. This profile of "Molly" is interesting in that we believe the general public would not question that she is "disabled," yet our Regional Medical Advisor's comments on this profile illustrate a contrasting viewpoint (Attachment 4).

In providing this background, we are not suggesting that the majority of disability denials and cessations on mental impairment claims are not appropriate. However, we believe that in a very small percentage of these claims, the case adjudication guidelines are applied too stringently.

Our Regional Medical Advisor has provided an analysis of the problem and has suggested some changes in the instructions for case-by-case application (Attachment 5). Briefly, he suggests a change in format and instructions for the psychiatric review form to provide for more equitable rating of the severity of certain mental impairments. Additionally, he cautions that assessment of the RFC involves more than translating the functional limitations to work-related capabilities. He suggests that the claimant's stress tolerance is also a critical factor in the RFC assessment. We believe this latter factor should be considered in POMS 2382.1C.

In summary, we look forward to the forthcoming instructional changes identified in your August 3, 1981 correspondence and hope you will consider the additional suggestions and comments that we are at this time providing. The overall number of mental impairment claims is increasing with the addition of the periodic reexam cases and we believe that the problems we have identified should be timely resolved.

If you have any additional questions regarding this correspondence, please contact Bonnie Becker of Programs - Disability Programs Branch at (FTS) 353-3312.

Marlene M. Moleski
Marlene M. Moleski
Acting Regional Commissioner

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to: SLC-22

# Memorandum

QA-11

Date: MAY 14 1982

From: Associate Commissioner
for Assessment

Subject: Continuing Disability Experience—October 1981 Through March 1982—INFORMATION

To: Commissioner of Social Security
Thru: ES____________________

At a recent staff meeting, Janice Warden presented data on the results of our quality assurance (QA) reviews of continuing disability investigation (CDI) cases. You asked that she send a memo to you reflecting our QA experience. These data are as follows:

CDI QA Data - October 1981 - March 1982

| Type of Cases | Cases Reviewed | Decisional Errors No. | Decisional Errors Pct. | Documentation Errors No. | Documentation Errors Pct. | Total Errors No. | Total Errors Pct. | Accuracy Rate |
|---|---|---|---|---|---|---|---|---|
| Continuances | 4,610 | 100 | 2.2 | 145 | 3.1 | 245 | 5.3 | 94.7 |
| Cessations | 3,987 | 62 | 1.6 | 112 | 2.8 | 174 | 4.4 | 95.6 |
| TOTAL | 8,597 | 162 | 1.9 | 257 | 3.0 | 419 | 4.9 | 95.1 |

These error data give an indication as to the overall quality of the CDI's, but we must keep in mind that cases returned through the QA process do not necessarily result in a change of decision. Sufficient time has not elapsed for us to gather data to determine the percent of CDI cases which will reverse as a result of the QA review. However, applying the most recent rates derived from the review of initial cases, we can calculate an expected net accuracy rate for CDI cases. The net accuracy rate is the percentage of cases where the decision does not change as a result of the review. From a net accuracy perspective, the above data become:

Net Accuracy
CDI QA Data - October 1981 - March 1982

| Type of Cases | Cases Reviewed | Decisional Errors No. | Decisional Errors Pct. | Documentation Errors No. | Documentation Errors Pct. | Total Net Errors No. | Total Net Errors Pct. | Net Accuracy Rate |
|---|---|---|---|---|---|---|---|---|
| Continuances | 4,610 | 69 | 1.5 | 52 | 1.1 | 121 | 2.6 | 97.4 |
| Cessations | 3,987 | 51 | 1.3 | 44 | 1.1 | 95 | 2.4 | 97.6 |
| TOTAL | 8,597 | 120 | 1.4 | 96 | 1.1 | 216 | 2.5 | 97.5 |

From these data we project that in any national CDI workload, 97.5 percent of the DDS decisions will be decisionally correct. Of course, individual DDS's will range above and below this accuracy rate.

We believe the following information may also be helpful. We have been tracking cessations from the 1980-81 CDI Redesign Study to determine the net cessation rate after appeals through the Administrative Law Judges (ALJ's). The most recent data show that 50.3 percent of the title II cases which are ceased by the DDS's are appealed to the ALJ's. (We expect this 50.3 percent filing rate to increase.) Of those appealed decisions, 67.2 percent are reversed to continuances. The result of this appeal activity is that two-thirds of the DDS cessations will remain cessations after ALJ review. Stated differently, whatever the DDS cessation rate may be, we can expect two-thirds of that rate to be a valid cessation rate through the ALJ appeal level. Therefore the overall reversal rate has been 21.9%.

We hope this information is useful.

Beverly A. Bedwell

# Executive Summary
# Disability Insurance National Pilot Study - Phase II
# July-September 1980

## Findings:

### Overall Discrepancy Findings

—Of the projected $3.7 billion paid to DI beneficiaries nationally during the sample period, a little over $1 billion was determined by quality review procedures to have been paid in error. This equates to a payment discrepancy rate of 27.8 percent.

—Approximately 98 percent of all excess payments were payments to beneficiaries who were not entitled to any benefits.

—Over 51 percent of the excess payments occurred because beneficiaries did not report improvement in their conditions or a return to work. It is noteworthy that, in these cases, the agency had not initiated or followed through on a continuing disability investigation subsequent to the latest determination in file.

--The case discrepancy rate for the period was 30.8 percent.

### Medical Discrepancy Findings

--98.6 percent of all excess payments involved medical entitlement factors.

—Almost 71 percent of all medical excess payments involved the musculoskeletal, cardiovascular or mental body system; these three body systems represent about 67 percent of the DI rolls.

—Over 41 percent of all cases involving DI beneficiaries age 40-49 were discrepant.

—The case discrepancy rate with regard to cases entitled between 1974 and 1977 was in excess of 34 percent.

—Over 43 percent of the discrepant cases were cases involving an allowance because the claimant's condition was found to "equal" the medical listings.

### Medical Deficiency Findings

--Over 97 percent of all deficiency excess payments was due solely to the wage earner's not being disabled.

Recommendations and Ongoing and Planned Special Studies:

--Cases involving musculoskeletal, cardiovascular, or mental disorders should continue to receive priority for review, both under the preeffectuation review and periodic review. Inconclusive data points to certain diagnoses within these body systems which may be low in error. These will be further studied as part of the ongoing quality review system.

--Since cases entitled during 1974-1977 were more error prone than cases entitled in subsequent years, these cases should be targeted for priority review.

--A 3,000 case sample involving DI beneficiaries age 40-49 was selected for review since cases in this age group were more error prone than cases in other age groups. We will be reporting on this study later this year.

--The Office of Assessment is now investigating the possibility of doing a special study on beneficiaries' failure to report medical improvement.

--Pilot II findings involving cases allowed because the claimant's condition "equals" the medical listings are being evaluated as a prelude to a possible special study.

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

AUG 18 '82

Honorable William S. Cohen
Chairman, Subcommittee on Oversight of Government Management
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cohen:

Attached are the answers to your follow-up questions to the Social Security Administration's May 25 testimony before the Subcommittee on Oversight of Government Management. The same material has also been sent to Senator Levin.

Sincerely,

(for) Paul B. Simmons
John A. Svahn

Enclosures

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NOTE: Two reports, "Overview: Disability Insurance National Pilot Studies I and II are retained in subcommittee files.

Question 1

In the March 6, 1981, memorandum from Sandy Crank, Associate Commissioner for Operational Policy and Procedures, to Fred Schutzman, Acting Deputy Commissioner (Operations), entitled "Periodic Review and Increasing Title II Disability Savings in FY 1982," it was projected that processing 30,000 Title II CDI cases per month would require an additional 545 positions above the March 1981 level. It was also stated that an additional 1,370 full-time positions would be assigned to process CDI cases. In testimony, the Social Security Administration stated that staffing had increased 33 percent between FY 1980 and FY 1982.

(a) Has the Social Security Administration added the recommended 545 positions?

(b) By quarter and by position, how many additional full-time positions in state determination offices and the Office of Hearing Appeals have been created as of June 1982?

(c) Similarly, how many existing full-time positions have been assigned to process CDI cases, by quarter and by position, during the same period?

(d) What are the current projections, by quarter and position, for staff increases to handle CDI cases in state agencies during the remainder of FY 1982, FY 1983, and FY 1984?

(e) How was the appropriate number of additional staff or staff reassignments derived or projected?

(f) What specific process was used by the Social Security Administration in making staff projections?

(g) Please include any determinations the Social Security Administration has made as to the number of CDI cases each disability examiner and ALJ can properly handle.

(h) How many state disability determination offices are or have been under a state hiring freeze between the months of March 1981 and June 1982?

(i) To what extent have these hiring freezes affected the Social Security Administration's projected staff increases and reassignments?

Because of the format of available data, our answers to your questions, except question (b), are expressed in equivalent full-time positions (total workpower divided by the number of hours in the DDS work-year, regardless of the actual mix of part-time and full-time employees needed to make up that workpower). The answer to question (b) relating to full-time positions by quarter is expressed in full-time positions (full-time positions being employees who work the full number of hours in a work-week or work-year.) The answers to your specific questions follow:

(a) Between March 1981 and March 1982, SSA increased DDS staffing by 2,045 equivalent full-time positions. Within that increase were the 545 positions necessary to process the additional continuing disability investigation (CDI) cases.

(b) The following table represents the total number of full-time employees on duty in DDS's by quarter and position between March 1981 and March 1982. Data through June 1982 are not available at this time.

| | 03/81 | 06/81 | 09/81 | 12/81 | 03/82 |
|---|---|---|---|---|---|
| Supervisors | 865 | 899 | 941 | 990 | 1,023 |
| Examiners | 4,265 | 4,434 | 4,927 | 5,186 | 5,226 |
| Clericals | 3,361 | 3,541 | 3,803 | 4,020 | 4,066 |
| Medical Consultants | 151 | 154 | 163 | 176 | 177 |
| Administrative | 959 | 963 | 998 | 1,041 | 1,067 |
| Total | 9,601 | 9,991 | 10,832 | 11,413 | 11,559 |

Office of Hearings and Appeals (OHA) staffing configurations cover only FY 1982 since no additional positions were allocated to OHA until the beginning of FY 1982, because most appeals on accelerated CDI cases did not start to come on line until the end of FY 1981.

OHA Staffing Configuration by Quarter
for Full-Time Permanent (FTP) Positions
FY 1982

| FTP Positions by Location | 12/81 (Actual) | 03/82 (Actual) | 06/82 (Projected) | 09/82 (Projected) |
|---|---|---|---|---|
| Central Office | | | | |
| Appeals Council Members | 13 | 14 | 15 | 15 |
| Hearings and Appeals Analysts | 281 | 276 | 315 | 330 |
| Workload Support | 400 | 392 | 414 | 479 |
| Staff Positions | 260 | 262 | 277 | 282 |
| Total Central Office | 954 | 944 | 1,021 | 1,106 |
| Field Offices | | | | |
| Administrative Law Judges | 731 | 750 | 783 | 810 |
| Decision Writers | 516 | 535 | 604 | 636 |
| Management | 119 | 125 | 130 | 135 |
| Hearings Assistants | 955 | 965 | 1,004 | 986 |
| Interpreters | 12 | 13 | 13 | 13 |
| Clerical | 1,327 | 1,287 | 1,455 | 1,763 |
| Staff Positions | 66 | 66 | 66 | 66 |
| Total Field | 3,726 | 3,741 | 4,055 | 4,409 |
| Total OHA | 4,680 | 4,685 | 5,076 | 5,515 |

(c) The State DDS's have the following equivalent full-time positions assigned to process CDI cases:

| Quarter | 3/81 | 6/81 | 9/81 | 12/81 | 3/82 |
|---|---|---|---|---|---|
| Equivalent FT Positions | 936 | 1,236 | 1,344 | 2,120 | 2,484 |

These are estimates derived by calculating the CDI workload as a proportion of the total workload since staff are not assigned to specifically process CDI cases. OHA has no positions specifically assigned to process CDI cases. In general, we estimate the CDI's will constitute 15.9 percent of the receipts of hearing requests this year, and a proportionate portion of OHA's staffing will be committed to processing this workload.

(d) The total number of State agency equivalent full-time positions that will be required to process the CDI workload are as follows:

| FY | 1982 | 1983 | 1984 |
|---|---|---|---|
| Positions | 2,203 | 2,751 | Not available |

(e) Staffing requirements and assignments are dependent on the workload forecasted and the actual or projected productivity required to process that workload.

(f) Staff projections were based on actual CDI productivity and a projection of what future productivity would be.

(g) For fiscal year 1982, DDS overall CDI productivity was projected at 208 cases processed per work-year. Productivity per work-year includes all elements of processing CDI cases and does not distinguish types of actions on each case.

OHA has established as a national goal an average of 40 case dispositions for all types of cases per month per fully-productive ALJ for FY 1982 and 45 per month for FY 1983.

(h) The following States were under a state imposed hiring freeze at sometime between March 1981 and the present:

Arizona
*California
Colorado
Florida
*Illinois
Indiana
*Iowa
*Kentucky
*Maine
*Maryland
Michigan
*Montana
*Nebraska
*Nevada
North Carolina
South Dakota
*Tennessee
Viriginia
*West Viriginia

An asterisk (*) indicates the impact of the freeze was significant on the DDS's ability to hire staff.

(i) In March 1981, SSA projected a need for 12,700 equivalent full-time employees in the DDS's by October 1981 based on anticipated workloads. At no time have we exceeded the equivalent of 12,600 employees in the DDS's, but since initial disability workloads have been lower than had been projected, the need for employees has also decreased.

Question 2

In testimony, the Social Security Administration stated that overall case processing time for state agencies and hearings rose in the first quarter of 1982 compared to the same quarter in 1981. Please provide a state-by-state breakdown of state agency and appeals hearings processing times for each quarter of 1981 through June 1982, as well as for FY 1979 and FY 1980, if available. If these processing times are available broken down into CDI cases and initial cases, please provide that breakdown.

A table showing hearings processing times for each region is attached. Hearings processing times are not available by state or for initial and CDI cases separately. This table also shows State agency processing times. The State agency information is only available from March 1981 through March 1982 and is not available for CDI and initial cases separately. Processing time data for 1979 and 1980 are not available. A separate chart is attached showing processing times by States.

### Title II/Title XVI Combined
### Hearings Processing Times
(Days)

| | | | FY 1981 | | | | FY 1982 | |
|---|---|---|---|---|---|---|---|---|
| | FY 1979 | FY 1980 | 1st Qtr. | 2nd Qtr. | 3rd Qtr. | 4th Qtr. | 1st Qtr. | 2nd Qtr |
| Boston | 167 | 177 | 194 | 196 | 196 | 207 | 208 | 203 |
| New York | 150 | 166 | 156 | 150 | 141 | 146 | 154 | 153 |
| Philadelphia | 158 | 166 | 170 | 136 | 187 | 189 | 185 | 187 |
| Atlanta | 141 | 147 | 143 | 151 | 150 | 154 | 147 | 144 |
| Chicago | 163 | 174 | 187 | 205 | 203 | 219 | 220 | 224 |
| Dallas | 148 | 161 | 158 | 165 | 157 | 158 | 155 | 163 |
| Kansas City | 128 | 151 | 159 | 172 | 171 | 178 | 173 | 174 |
| Denver | 158 | 178 | 171 | 169 | 160 | 158 | 184 | 181 |
| San Francisco | 155 | 148 | 139 | 137 | 139 | 145 | 155 | 174 |
| Seattle | 156 | 150 | 163 | 172 | 134 | 186 | 189 | 208 |
| National | 151 | 159 | 159 | 165 | 164 | 170 | 170 | 174 |

### Title II Only
### State Agency Processing Times
(Days)

| | | | | FY 1981 | | | FY 1982 | |
|---|---|---|---|---|---|---|---|---|
| | FY 1979 | FY 1980 | 1st Qtr. | 2nd Qtr. | 3rd Qtr. | 4th Qtr. | 1st Qtr. | 2nd Qtr. |
| Boston | | | | 45 | 43 | 46 | 48 | 46 |
| New York | | | | 57 | 53 | 54 | 57 | 58 |
| Philadelphia | | | | 45 | 43 | 47 | 53 | 55 |
| Atlanta | | | | 39 | 35 | 40 | 44 | 43 |
| Chicago | | | | 46 | 42 | 48 | 49 | 51 |
| Dallas | | | | 44 | 39 | 41 | 46 | 46 |
| Kansas City | | | | 38 | 35 | 40 | 42 | 41 |
| Denver | | | | 47 | 43 | 45 | 48 | 49 |
| San Francisco | | | | 46 | 43 | 47 | 53 | 63 |
| Seattle | | | | 42 | 40 | 43 | 44 | 40 |
| National | | | | 45 | 41 | 46 | 49 | 50 |

# TITLE II ONLY
# DDS PROCESSING TIME

(DAYS)

| QUARTER ENDING: | | | 3/81 | 6/81 | 9/81 | 12/81 | 3/82 |
|---|---|---|---|---|---|---|---|
| UNITED STATES | | | 45 | 41 | 46 | 49 | 50 |
| Boston | Connecticut | | 45 | 41 | 45 | 47 | 46 |
| | Maine | | 36 | 33 | 37 | 38 | 40 |
| | Massachusetts | | 45 | 45 | 48 | 46 | 45 |
| | New Hampshire | | 44 | 38 | 45 | 58 | 42 |
| | Rhode Island | | 56 | 48 | 56 | 64 | 63 |
| | Vermont | | 46 | 43 | 47 | 45 | 45 |
| | * | | 45 | 43 | 46 | 48 | 46 |
| New York | New Jersey | | 61 | 57 | 61 | 64 | 64 |
| | New York | | 54 | 49 | 51 | 52 | 53 |
| | Puerto Rico | | 55 | 55 | 61 | 71 | 74 |
| | * | | 57 | 53 | 54 | 57 | 58 |
| Philadelphia | Delaware | | 63 | 60 | 72 | 87 | 95 |
| | District of Columbia | | 52 | 47 | 53 | 59 | 58 |
| | Maryland | | 45 | 41 | 45 | 53 | 59 |
| | Pennsylvania | | 44 | 43 | 47 | 50 | 50 |
| | Virginia | | 43 | 39 | 42 | 50 | 56 |
| | West Virginia | | 51 | 47 | 54 | 60 | 60 |
| | * | | 45 | 43 | 47 | 53 | 55 |
| Atlanta | Alabama | | 47 | 44 | 41 | 43 | 51 |
| | Florida | | 35 | 30 | 32 | 34 | 34 |
| | Georgia | | 35 | 34 | 36 | 39 | 40 |
| | Kentucky | | 41 | 34 | 38 | 45 | 48 |
| | Mississippi | | 36 | 31 | 35 | 35 | 35 |
| | North Carolina | | 37 | 38 | 49 | 52 | 43 |
| | South Carolina | VR | 40 | 36 | 42 | 43 | 42 |
| | | Bing | - | - | - | - | - |
| | Tennessee | | 41 | 39 | 51 | 60 | 56 |
| | * | | 39 | 35 | 40 | 44 | 43 |
| Chicago | Illinois | | 47 | 41 | 48 | 49 | 52 |
| | Indiana | | 61 | 62 | 65 | 65 | 69 |
| | Michigan | | 44 | 41 | 46 | 48 | 46 |
| | Minnesota | | 44 | 40 | 45 | 49 | 52 |
| | Ohio | | 42 | 38 | 43 | 46 | 47 |
| | Wisconsin | | 42 | 37 | 39 | 41 | 44 |
| | * | | 46 | 42 | 48 | 49 | 51 |
| Dallas | Arkansas | | 36 | 33 | 34 | 36 | 35 |
| | Louisiana | | 34 | 31 | 33 | 37 | 40 |
| | New Mexico | | 52 | 49 | 53 | 51 | 45 |
| | Oklahoma | | 46 | 39 | 40 | 46 | 42 |
| | Texas | | 48 | 42 | 45 | 53 | 51 |
| | * | | 44 | 39 | 41 | 46 | 46 |
| Kansas City | Iowa | | 35 | 32 | 34 | 36 | 35 |
| | Kansas | | 48 | 46 | 44 | 41 | 38 |
| | Missouri | | 36 | 31 | 42 | 46 | 45 |
| | Nebraska | | 37 | 35 | 39 | 40 | 37 |
| | * | | 38 | 35 | 40 | 42 | 41 |
| Denver | Colorado | | 52 | 46 | 49 | 51 | 48 |
| | Montana | | 37 | 37 | 43 | 46 | 53 |
| | North Dakota | | 56 | 46 | 46 | 49 | 50 |
| | South Dakota | | 33 | 32 | 33 | 36 | 36 |
| | Utah | | 45 | 43 | 45 | 50 | 56 |
| | Wyoming | | 51 | 45 | 44 | 45 | 47 |
| | * | | 47 | 43 | 45 | 48 | 49 |
| San Francisco | Arizona | | 41 | 40 | 45 | 51 | 53 |
| | California | | 47 | 43 | 48 | 54 | 65 |
| | Guam | | - | - | - | - | - |
| | Hawaii | | 35 | 33 | 38 | 42 | 52 |
| | Nevada | | 44 | 37 | 45 | 43 | 39 |
| | * | | 46 | 43 | 47 | 53 | 63 |
| Seattle | Alaska | | 54 | 51 | 51 | 42 | 37 |
| | Idaho | | 38 | 38 | 41 | 40 | 41 |
| | Oregon | | 37 | 34 | 36 | 38 | 36 |
| | Washington | | 45 | 41 | 47 | 48 | 43 |
| | * | | 42 | 40 | 43 | 44 | 40 |

Form SSA-2564 (7-78) (Formerly CO-1770) (Destroy prior editions)

*Regional Average

Question 3

From March 1981 to December 1981, how many diaried title II cases have been reviewed, and from January 1982 through June 1982? How many diaried cases were pending in December 1980, compared to December 1981, and June 1982? Please provide a list of those impairments which trigger the designation of the title II case as "diaried."

From April 1, 1981 through December 1981, 92,941 diaried title II cases were reviewed. From January 1982 through March 1982, 31,385 diaried title II cases were reviewed. (Data through June 1982 are not available at this time.) In December 1980, 26,603 diaried title II cases were pending versus 26,393 diaried title II cases pending in December 1981.

In regard to the last part of the question, we have attached a copy of POMS sections DI 2500-2504. These sections indicate those impairments which, at the time of initial entitlement, are diaried for a future reexamination. These impairments may also be rediaried or diaried for the first time at the time of a determination of continuing entitlement, but this is a rare occurrence. Also attached is a copy of POMS section DI 2877 which contains a list of those impairments or, perhaps more accurately, circumstances which account for the greatest number of diaries or rediaries at the time of a determination of continuing entitlement. Of course, even if a subsequent medical diary is not established, the beneficiary's status may be reviewed in the future under the periodic review process.

any, by an individual in determining whether there is an ability to engage in substantial gainful activity.

Accordingly, if a member of the Armed Forces is not engaged in the performance of substantial gainful activity, onset should be established as of the first day he or she became unable to work by reason of a medical impairment.

# The Medical Reexamination Diary

## 2500. General

The medical reexamination diary procedure is one of several techniques used to initiate an investigation of an individual's continuing entitlement to the "freeze" and to title II and/or title XVI benefits. This is a basic procedure whereby a continuing disability investigation is undertaken for those individuals whose impairments are expected to improve sufficienly to permit them to engage in substantial gainful activity.

The following sections provide instructions on the selection of cases for medical reexamination diary and the appropriate due date for a diary. Also provided is information on how to handle special situations involved in establishing diaries for title XVI cases for those individuals age 18 or over and individuals under age 18 where, in the best judgment of the DDS adjudicative team, the guides are applicable. The effectiveness of the continuing disability policy discussed under DI 2877 depends largely upon the appropriate use of the diary.

While these instructions are concerned primarily with the initial diary, it is contemplated that they may also be useful in dealing with the issue of rediary. However, in the latter instance they can only be applied within the context of DI 2877.

## 2501. Selecting Cases for Diary

The question of whether a case should be diaried for medical reexamination depends on whether significant medical improvement which would enable the individual to return to work, can reasonably be expected. Experience has shown that in certain types of cases the likelihood of significant medical improvement is sufficiently great to warrant a routine medical reexamination diary on initial adjudication. The categories of cases that require diary are specified in DI 2502. Experience has also shown that the incidence of medical recovery decreases markedly with advancing age. Thus, the mandatory diary categories are not applicable to any case in which the proposed diary would mature at age 62 or later (age 60 or later in cases involving disabled widows and widowers benefits under title II). However, these cases, as well as all other cases in which a diary is not mandatory, are subject to the optional diary procedures described in DI 2503. No diary should be set in any case in which the proposed diary would mature at age 64 1/2 or later. Following is a summary of the criteria for selecting cases for diary:

### *A. Mandatory Cases*

Diary any case which involves an impairement category specified in DI 2502, except cases in which the proposed diary would mature at age 62 or later (age 60 or later in cases involving disabled widows and widowers benefits under title II).

### *B. Optional Cases*

Apply the optional diary procedure to any case in which a diary is not mandatory, except cases in which the proposed diary would mature at age 64 1/2 or later.

In those cases where a diary is required, or is deemed to be appropriate, the SSA-831-U5 should be completed in accordance with DI 3017 or 3117.

## 2502. Mandatory Diary Catagories

Where the primary impairement is one which is listed below, a diary is required, except where there is another impairement(s) present which is chronic or progressive, and sufficient overall improvement to permit a finding that the individual is no longer disabled cannot be reasonably anticipated. (Development of severity of an additional impairement should not be undertaken merely to establish whether a diary is warranted.) Because of significant differences in the nature of and prognosis for certain medical conditions in children as compared with adults, section B below provides some mandatory diary categories applicable only to children.

### *A. Impairements Categories Applicable to Adults and Children*

1. Respiratory disease based on frequency of acute episodes (e.g., asthma, bronchiectasis).
2. Functional psychotic disorders where onset is established within the 2-year period preceding the determination of disability (see note below).
3. Functional nonpsychotic disorders.
4. Active rheumatoid arthritis, or other inflammatory arthritis, without residual structural deformity.
5. Any case in which corrective surgery is planned or where adjudication takes place during the postsurgical convalescent period and recovery can be anticipated. This includes cases involving cardiovascular and renal surgery, laryngectomy, peripheral vascular surgery, laminectomy, and lumbar (lumbosacral) fusion.
6. Obesity - in and of itself producing manifestations limiting work capacity.
7. Fractures(s) of any bone(s) without severe residual functional loss or structural deformity which is by itself disabling.
8. All infections (e.g., tuberculosis, mycosis, leprosy, osteomyelitis) without severe, irreversible structural damage.
9. Peripheral neuropathies.
10. Sarcoidosis without severe organ damage, e.g., pulmonary, ocular, renal, etc.

11. Progressive neoplastic disease is highly probable but full medical work-up falls short of a definite diagnosis.

12. Neoplastic disease which has been treated an incapacitating residuals exist, but improvement of those residuals is probable.

13. Epilepsy.

14. Acute leukemia - onset within 2 1/2 years of determination.

15. Central nervous system trauma where progressive improvement of function is evident, but the impairment is expected to be disabling at 12 months from onset.

16. All back conditions amenable to treatment, where permanently incapacitating residuals are not established.

NOTE: *Where, because of technial considerations, onset is set at a date later than the actual beginning date of disability, e.g., in relation to the prescribed period of DWB cases or the application date as onset in title XVI cases the 2-year period should be determined on the basis of the actual date the impairment became disabling.*

### *B. Supplemental Categories—Applicable to Children Only*

1. Mental deficiency, where testing is performed under the age of 16.
2. Growth impairments—all cases allowed under listing 100ff.
3. Endocrine disorders—all cases allowed under listing 109ff, except those meeting Listing 109.05A or 109.08D.
4. Lymphoreticular malignant neoplasms.
5. Malignant solid tumors.

## 2502.1. Special Diary Criteria for Title XVI DA&A Cases

All cases in which the drug addiction and alcoholism (DA&A) systems indicator is imposed (or retained after a CDI) should be diaried (or rediaried) for medical reexamination with a date set for 12 months following the month of adjudication. The need to establish an additional medical reexamination and conduct another CDI in 12 months is based upon the following reasons:

A. It is anticipated that continued treatment of drug addicts or alcoholics should result in medical improvement and recovery; hence, individuals whose disability is established (or continued) on the basis that drug addiction or alcoholism is relevant to the determination are expected to recover as a result of required treatment and resume the ability to engage in SGA.

B. The maintaining of a medical reexamination diary assures that followup action will be taken to reevaluate an individual's progress in terms of therapeutic benefit; it also assures administrative control and contact with the VR (or other agency) referral and monitoring function in order that the effectiveness of reporting procedures can be periodically reassessed and adjusted if necessary.

## 2503. Optional Diaries

While the mandatory diary categories have been identified as being the most likely to result in recovery or significant medical improvement they are, of course, not all-inclusive. The factors involved in this issue are so many and varied that it is not possible to construct a list of categories which would be of manageable length. Accordingly, in all cases where a reexamination diary is not required under DI 2502 a medical judgment must be made by the reviewing physician based on the facts of the individual case, as to whether a medical diary is appropriate. A diary should be established in any case in which there is a reasonable expectation that the individual will regain ability to work.

When an optional diary is established, items 17 (reexam block) and 26 (Listing Number block) of the SSA-831-U5 should be completed in accordance with DI 3017 and 3026 for title II and 3117 and 3126 for title XVI. Identification of optionally-diaried cases will enable ODP to monitor them for identification of possible new categories for compulsory diary, and to determine the productivity of the optional method.

## 2504. Setting a Time for Medical Reexamination

### *A. General*

Careful consideration must be given to the clinical findings, past response to therapy, the type of treatment, and the expected clinical course of the impairment in each case when setting the month and year for a medical reexamination diary. Generally, it will not be possible to pinpoint an exact month when recovery will occur, and development should not be undertaken solely for the purpose of establishing a medical reexamination diary date. This decision should be based on the evidence of record at the time the finding of disability is made, with careful attention to the objective of avoiding premature diaries.

A medical reexamination diary should generally not be set for less than 6 months or for more than 18 months after adjudication, except in child cases because the child's impairment (e.g., epilepsy) may become significantly less severe as the child grows and develops, or in adult cases where allowance is based on a listing section lending specifically to a long-term dairy (e.g., DI 7.11, acute leukemia). Instructions for recording these long-term diary dates are contained in DI 3117. In most cases, where recovery cannot be reasonably anticipated within 18 months of adjudication, diaries have been found to be highly speculative and almost entirely unproductive. In no event should a diary be scheduled within 12 months of the actual onset of disability, except in title XVI blind cases.

In title XVI cases, when blindness is alleged, the expected duration of the impairment is not a factor in determining whether blindness exists. Therefore, it may be appropriate to set a shorter diary period in certain cases, e.g., cataracts. This judgment should be made by the DDS physician based on the evidence of record. The facts of each blindness case should dictate the setting of the reexamination date for the month in which it is expected that the impairment will have improved to the extent that the statutory definition will no longer be met.

### *B. Special Considerations for Timing Diary of Title XVI Child Claims*

**1. MENTAL DEFICIENCY (SEE NOTE BELOW)**

a. If child is below age 7 at adjudication

(1) set diary 2-~~3~~ 5 years from date of adjudication if IQ is under 40

(2) Set diary 1-3 years from date of adjudication if IQ is 40 or above

b. If child is age 7 or over at adjudication

(1) set diary 3-~~5~~ years from date of adjudication if IQ is under 40

(2) set diary 2-~~4~~ years from date of adjudication if IQ is 40 or above 3

**NOTE:** *The timeframes for reexamination of mental retardation are made flexible so that all the factors having a bearing on the issue (e.g., behavior and daily activities) can be considered in determining the best time for reexamination.*

**2. SCOLIOSIS**

Set diary 1-year from date of surgery

**3. LYMPHORETICULAR MALIGNANT NEOPLASMS**

Set diary for 2½ years from time of initial disanosis or time of recurrence of active disease

**4. MALIGNANT SOLID TUMORS**

Set diary for 2 years from time of initial diagnosis or time of active disease.

**NOTE:** *See DI 2877 for diarying cases after a continuing disability investigation.*

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current title II/title XVI cases, the second signature will be included on the title II determination as well as the title XVI.)

Second team signatures (SSA-833-U5) and initials (SSA-834-U5), along with dates, are needed on the SSA-833-U5 and SSA-834-U5, respectively.

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## 2877. Diary of Cases After Continuing Disability Investigation

J.R. 72370 72831

A. When a continuing disability investigation based on a prior medical reexamination diary results in a continuance, the lapse of time during which the expected significant medical improvement did not occur decreases the probability of finding medical recovery at some future date. Accordingly, a medical rediary should not be established unless there is a clear medical basis for expecting sufficient improvement to justify cessation. Minor symptomatic improvement, or improvement that does not relate to a significant increase in functional capacity, should not be used as a basis for scheduling a medical rediary. Unless definite and sustained improvement has taken place since onset, any expectation of medical recovery would ordinarily be speculative unless the evidence provides a sound basis to expect the return of capacity to engage in substantial gainful activity.

NOTE: *In all continuances where drug addiction or alcoholism is material to the finding of disability the DDS will establish a 12 month medical reexamination diary (DI 2878B).*

B. Experience has shown that where medical recovery cannot be established within 3 years of onset of disability, it rarely can be found at any future date. Therefore, where the established onset date precedes, by 3 years or more, the date of the current decision to continue disability, no medical rediary should be established unless there is a compelling reason which has been clearly documented at the time of the current CDI. For purposes of this section, compelling reasons for rediary include, but are not limited to, the following situations:

1. Surgery which is too recent to permit evaluation of the residual impairment; or
2. Surgery to restore functional capacity is contemplated but has not, as yet, been performed; or
3. Disability based on the impairment for which the previous diary was set has ceased; however, another disabling impairment has been superimposed and significant improvement is anticipated.
4. Past medical treatment has failed to produce significant improvement but a different course of medical treatment is planned or is underway and it is anticipated that there may be a significant response to that treatment.

C. As with initial diaries, the timing of rediaries is of utmost importance. Generally, in those cases where recovery is not established, documentation at the time of the CDI would be expected to facilitate judgment not only as to whether recovery may be anticipated but also when it is likely to occur.

In contrast with initial diaries, a rediary should ordinarily be for a shorter period than the initial diary and should rarely, if ever, exceed 12 months. A 12-month rediary should be established only where a more precise earlier time of possible recovery cannot be determined.

Where a rediary is deemed to be appropriate, the SSA-833-U5 should be completed in accordance with DI 2875.

## 2878. Establishing and Cancelling Medical Reexamination Diary Control Title XVI

### *A. Continuing Disability Action Completed*

Following most continuing disability actions an SSA-833-U5 determination is prepared. In title XVI and concurrent title II/title XVI claims where the CDI results in a cessation, the DDS should establish an appropriate cessation diary: "N7" (disability cessation) or "N8" (blindness cessation), which will be alerted to the district office upon maturity for their action to terminate payments. Followup diaries will be generated at 30-day intervals. Copies of the third and sixth followups will be provided to regional offices as well as DO's. District offices have the capability to extend to delete diary dates. Additionally, the system will automatically suppress or clear the diary if the appropriate Goldberg-Kelly (GK) code is annotated to the record or the payment status is any "T" code, N03, N07 through N19, or the person is age 65 or older.

When an N7 or N8 diary is being established, the SSI system will, upon receipt of the cessation diary, search for a medical reexamination diary. *If a medical reexamination diary is present on the SSR, it will be deleted and the cessation diary will be established.* Therefore, when processing cessation cases, it will not be necessary to transmit a diary deletion for the MR diary.

Cessation diaries may be established for *no less than 20 days* and *no more than 60 days*. If an "N7" or "N8" diary is established for less than 20 days or more than 60 days, a surface edit code 26 will result and the data will have to be retransmitted correctly.

Guidelines for establishing cessation diary dates are contained in POMS, part 8, SM 59047.C.

When preparing a continuance on a title XVI case, prepare a form SSA-4648-U3 to input a future diary date or to cancel the current diary. See POMS, part 8, SM 59047.A and E.

### *B. Continuing Disability Action Completed Where Drug Addiction and/or Alcoholism Is Involved—Title XVI Only*

In all continuances where drug addiction and/or

Question 4

In testimony, the Social Security Administration stated that "while processing times had increased, the accuracy rate for initial state agency terminations had improved somewhat." How is the accuracy rate defined? Please provide the specific accuracy rate for terminations for each quarter of 1981 through June 1982. What is the process for determining accuracy rates?

Deficient cases are defined as:

(a) cases in which the medical and vocational documentation supports a different decision than that made by the State Disability Determination Service (DDS), and

(b) cases in which missing medical or vocational documentation could potentially reverse the decision made by the DDS.

Federal reviewers use the above criteria in reviewing a sample of DDS determinations. Results of reviews over a period of time are used to calculate QA accuracy rates. The sample is designed to produce a 6-month CDI performance accuracy measure for each State. The following table shows the accuracy of continuing disability determinations for 6-month periods beginning with the period ending March 1981.

QA Accuracy Rate

| Period | Continuances | Cessations | Overall |
|---|---|---|---|
| 09/80 - 03/81 | 92.8 | 94.8 | 93.2 |
| 04/81 - 09/81 | 90.5 | 95.9 | 92.2 |
| 10/81 - 03/82 | 94.7 | 95.6 | 95.1 |

Cases returned to the DDS's using the aforementioned criteria do not necessarily result in a change of decision. The "net accuracy rate" reflects the percentage of cases reviewed in QA, in which the original decision by the DDS was determined to be correct even after additional documentation was obtained. The following table shows the net accuracy rates for the same three 6-month periods.

Net Accuracy Rate

| Period | Continuances | Cessations | Overall |
|---|---|---|---|
| 09/80 - 03/81 | 96.5 | 97.2 | 96.6 |
| 04/81 - 09/81 | 95.4 | 97.8 | 96.1 |
| 10/81 - 03/82 | 97.4 | 97.6 | 97.5 |

Question 5

In testimony, the Social Security Administration stated that 44 percent of the deficit in all Social Security trust funds could be attributed to the payment of disability benefits to those who are not disabled under the letter of the law, and that $11 million per day is going to people who are ineligible under the law. As specifically as possible, how were the 44 percent figure and the $11 million figure derived?

The $11 million per day is based on the findings of the special study (DI Pilot II) of 2,817 disabled workers who were receiving Social Security benefits during July-September 1980. Specifically, the study indicated that 30.8 percent of these workers received erroneous benefit payments of $1 billion during the period. When the $1 billion is projected to the entire Social Security disability beneficiary rolls, the total erroneous payments for 1980 are $4 billion--or about $11 million a day.

The 44 percent figure expresses the relationship between the $4 billion in erroneous payments and the estimated total deficit for the Old-Age, Survivors and Disability Insurance (OASDI) and Hospital Insurance (HI) Trust Funds for 1982. Four billion dollars is about 44 percent of $9.06 billion in OASDHI deficit projected for 1982 under the alternative II-B intermediate assumptions in the 1982 Reports of the Board of Trustees of the Social Security trust funds. (After adjustment to reflect the actual 7.4 percent COLA, instead of the projected 7.6 percent, the estimated 1982 deficit is about $8.9 billion and the $4 billion represents about 45 percent of that amount.) The $4 billion annual figure was used for this calculation since the total program deficit is normally prepared on an annual basis rather than for shorter periods of time.

**Question 6**

In the testimony, the Social Security Administration stated that the reason people are being taken off the rolls is not that there are deficiencies in the process, but because they are not disabled under the terms of the law. The Social Security Administration also stated that many are on the rolls erroneously and many have recovered since they entered the rolls. Please provide the number of terminations since March 1981 for each of the reasons:

(a) there was an error in the initial disability determination;

(b) the beneficiary was engaged in substantial gainful activity;

(c) the beneficiary was no longer disabled due to medical improvement;

(d) the requirements of the law changed;

(e) the interpretation of the law changed;

(f) other.

If this information is not available precisely in this form, please provide it in the form in which it is available and the form on which the testimony is based.

The most recent data available are for the period December 1981 through March 1982, when cessations were based on the following causes:

| Basis for Cessation | Disabled Worker Cessations (Title II) December 1981 - March 1982 |
|---|---|
| Medically Ineligible | 59,158 |
| Returned to Work (SGA) | 3,158 |
| Whereabouts Unknown | 568 |
| Failure to Cooperate | 1,168 |
| Other or Unknown | 2,336 |
| TOTAL | 66,388 |

In our current termination data we do not separately identify cases where the beneficiary was put on the rolls erroneously and those where he was put on correctly but has since recovered. To do so would in effect double our CDI workload because State agency adjudicators would have to make two determinations: first, whether the beneficiary currently meets the definition of disability, and second, whether he or she met the definition at the time the initial disability determination was made, which could be many years ago. To make the latter determination, the adjudicators would have to consider all the old medical evidence in the file and would have to use the disability regulations in effect at the time of the initial determination, since current regulations reflect advances in medical evidence and therapy.

However, it is clear from other data that substantial numbers of people are on the benefit rolls erroneously either because the initial determination was erroneous or because they recovered but were not removed from the rolls because their cases were not reviewed. This was especially true in the 1970's. As mentioned in the testimony, the advent of the black lung program in 1970 and the SSI program in 1974, both requiring disability decisions, resulted in tremendous pressure to process claims quickly and reduce backlogs. Unfortunately, in order to hold down processing costs, quality was sacrificed to quantity. For example, until 1972, SSA reviewed a majority of State allowances before payment was made. In 1972, SSA moved to a sample review procedure of only 5 percent of allowances and performed the reviews after the benefits were awarded. Data from our DI Pilot Study II, conducted in 1980, show that the State agency case error rate in the years 1974-1977 was 22 percent higher than for years before 1974, and 51 percent higher than for years after 1977. This study shows that the highest case discrepancy rate was found in cases where the year of entitlement was 1974 (35.2 percent) although only 8.7 percent of all sample cases were entitled in that year. (Table from Pilot Study II attached.) Data from the CDI Redesign Study, conducted in 1980 and 1981, reflect similar findings.

Another measure SSA took to handle the higher workloads was to process fewer CDI's. Prior to 1970, SSA did CDI's on about 10 percent of beneficiaries on the rolls. However, during the early 1970's, SSA reduced the CDI's to just over 4 percent of the beneficiaries on the rolls. Termination rates steadily dropped from 108 per 1000 in 1969 to about 68 per 1,000 in 1976. SSA actuaries, in a report published in January 1977, "Experience of Disabled-Worker Benefits under OASDI, 1965-74" explained the rapid decrease in the termination rates as a result of progressively healthier beneficiaries being allowed to continue receiving benefits without being terminated.

Perhaps the most significant indication that people were put on the rolls erroneously during the 1970's is the steadily increasing trend in the disability incidence rate (the number of disability beneficiaries per 1000 workers during the period from 1970 to 1975. The rate went from 4.7 in 1970 to an all time high of 7.1 in 1975 even though the rates of sickness and injury did not change appreciably in the general economy. SSA actuaries, in the January 1977 report mentioned above, cited administrative factors as having played an important part in the increases.

Even today, some beneficiaries are put on the rolls erroneously. We will never have 100 percent accuracy in State agency disability determinations, given the nature of the disability determination process and the size of the program. However, we have made significant improvements. Data from our DI Quality Assurance System indicates that the percentage of erroneous State agency decisions was as high as 8 percent as recently as 1977 when QA data first became available but is now around 4 percent. As I said in my testimony there is always room for improvement and we are undertaking a number of initiatives aimed at making improvement.

With regard to (d) and (e), the requirements of the law--i.e., the definition of disability and the requirements that decisions be based on medical and vocational evidence--have not been made stricter so that beneficiaries would no longer meet the requirements. However, due to the availability of kidney transplants, bypass surgery, and new medications for mental illness, for example, certain medical conditions which were considered disabling in the past may not be disabling today. We do not have data on how many cases fall into this category.

## TABLE II-5

## DI PILOT II
## Body System - Case Discrepancy Rate
## By Year of Entitlement
## Medical Discrepancies Only

| | Prior to 1974 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | TOTAL | NUMBER OF SAMPLE CASES |
|---|---|---|---|---|---|---|---|---|---|---|
| MUSCULOSKELETAL | 34.6 | 45.8 | 43.9 | 38.0 | 33.8 | 31.7 | 27.9 | 21.1 | 35.9 | 724 |
| SPECIAL SENSES | 2.8 | 0.0 | 16.7 | 0.0 | 8.3 | 16.7 | 0.0 | 100.0 | 6.5 | 93 |
| RESPIRATORY | 14.0 | 21.4 | 18.8 | 25.0 | 26.7 | 28.6 | 26.3 | 0.0 | 20.1 | 159 |
| CARDIOVASCULAR | 25.6 | 33.3 | 29.4 | 23.7 | 37.2 | 28.0 | 22.1 | 10.3 | 27.1 | 757 |
| DIGESTIVE | 55.6 | 100.0 | 50.0 | 83.3 | 40.0 | 33.3 | 50.0 | 60.0 | 57.1 | 49 |
| GENITO-URINARY | 44.4 | 40.0 | 0.0 | 100.0 | - | 50.0 | 0.0 | 50.0 | 37.5 | 24 |
| HEMIC/LYMPHATIC | - | 0.0 | 0.0 | - | 100.0 | - | 0.0 | 0.0 | 20.0 | 5 |
| SKIN | 50.0 | 0.0 | - | 0.0 | - | 50.0 | - | - | 33.3 | 6 |
| ENDOCRINE | 46.2 | 16.7 | 37.5 | 15.4 | 20.0 | 33.3 | 14.3 | 0.0 | 25.4 | 59 |
| MULTIPLE | 25.0 | 25.0 | 0.0 | 75.0 | 33.3 | 66.7 | 25.0 | 0.0 | 33.3 | 30 |
| NEUROLOGICAL | 11.4 | 13.3 | 35.0 | 20.0 | 26.1 | 17.4 | 20.0 | 16.7 | 18.0 | 206 |
| MENTAL | 27.8 | 37.1 | 38.5 | 45.7 | 39.4 | 33.3 | 30.0 | 28.6 | 32.9 | 426 |
| NEOPLASTIC | 33.3 | 50.0 | 16.7 | 60.0 | 41.7 | 31.3 | 18.2 | 6.3 | 28.6 | 84 |
| OTHER | - | - | - | 100.0 | 0.0 | 100.0 | - | - | 66.7 | 3 |
| NOT CODED | 39.0 | 38.1 | 30.8 | 34.4 | 33.3 | 27.8 | 17.6 | 25.0 | 33.3 | 192 |
| TOTAL | 27.9 | 35.2 | 34.8 | 32.7 | 33.0 | 29.5 | 22.4 | 16.0 | 29.6 | 2,817 |

SOURCE: SPSS (11/25/81)(2/18/82)

Question 7

In 1980, the Social Security Administration conducted a study of 25,000 Title II cases, representing 60 percent of all disabled beneficiaries. The study found that 33 percent of these beneficiaries no longer met the requirements of the law. Of these beneficiaries, what percentage, or how many, no longer met the requirements of the law because:

(a) there was an error in the initial disability determination;

(b) the beneficiary was engaged in substantial gainful activity;

(c) the beneficiary was no longer disabled due to medical improvement;

(d) the requirements of the law changed;

(e) the interpretation of the law changed;

(f) other.

Again, if this information is not available in precisely this form, please provide it in the form from which the 33 percent conclusion was drawn.

(a) We did not gather data in the 25,000 case study as to how many of the terminations were put on the rolls erroneously in the first place.

(b) Of the 7,304* terminations in the study, 189 (or 2.6 percent) were terminated because the beneficiaries were engaged in substantial gainful activity.

(c) Federal review physicians made a determination that 3,761 (or 51.5 percent) of terminated beneficiaries in the study experienced medical improvement.

(d)&(e) The requirements of the law--i.e., the definition of disability and the requirements that decisions be based on medical and vocational evidence--have not been made stricter so that beneficiaries would no longer meet the requirements. However, due to the availability of kidney transplants, bypass surgery, and new medications for mental illness, for example, certain medical conditions which were considered disabling in the past may not be disabling today. We do not have data on how many cases fall into this category.

(f) In addition, 985 beneficiaries (or 26.2 percent) were terminated because they were medically ineligible and physicians were unable to determine whether they had experienced medical improvement. When added to (b) and (c) above, this accounts for 67.6 percent of the total terminations in the study.

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*Although the study involved 25,000 cases, complete data was received from only 21,896 cases. Of the 21,896 cases, 7,304 or 33 percent were terminations.

1 of 1

Question 8

Similarly, the Social Security Administration stated that another special SSA review of 2,800 cases indicated that 30 percent of recipients were not entitled to benefits and that as much as $4 billion annually was being paid to people who were not disabled. Please provide the Subcommittee with a complete copy of the results of this review (the Disability Insurance National Pilot Study--Phase II) and the Disability Insurance National Pilot Study--Phase I, and describe the methods, definitions, and full findings of both.

A copy of the results of Phases I and II of the Disability Insurance National Pilot Studies is attached.

Question 9

A May 14, 1982, memorandum from Beverly Bedwell, Associate Commissioner for Assessment to the Commissioner, presents data on the results of the Social Security Administration's quality assurance (QA) reviews of CDI reviews. Based on that memorandum, please provide the following information:

(a) How were the 8,597 cases selected, and at what stage of the case processing were they at the time of selection (e.g., state agency, state agency after reconsideration, etc.)?

(b) How were "decisional errors" and "documentation errors" defined?

(c) What has been the actual percentage of cases which have been reversed by state DDS's as a result of the QA review, for cessations and allowances?

(d) Please provide a complete copy of the 1980-81 CDI Redesign Study.

(e) The memorandum indicates that at that time 50.3 percent of all terminations were appealed to ALJ's, and that the Social Security Administration expected that percentage to increase. What is the current rate of appeals to the ALJ level? What is the current rate of ALJ allowances on appeal?

(a) The 8,597 cases were selected randomly from all CDI determinations made by the State disability determination services during the October 1981-March 1982 period. Virtually all of these cases were selected prior to reconsideration.

(b) Decisional errors are defined as decisions based on sufficient medical and vocational evidence where the reviewer decides an opposite determination is indicated by the evidence. Documentation errors are defined as decisions based on medical or vocational evidence insufficient to support a decision, when the missing evidence has some potential for reversing the decision.

(c) There is necessarily a lag between the time a case is returned to the DDS for the required medical evidence before a final decision is made, and consequently we do not have final results for all of the cases returned to State agencies by QA reviewers. However, results have been received for 29 percent of the returns in the October 1981-March 1982 period. The reversal rate has been 62 percent each for continuances and cessations. Based on experience for past periods we expect this rate will decline to about 55 percent when all the returns are completed for this period.

(d) A copy of the study is attached.

(e) We do not have more current data on the percentage of terminations that are appealed to the hearing level. The rate of ALJ allowances for CDI cases was 61 percent from February through April 1982.

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[NOTE.—Balance of answer to this question, "Title II Continuing Disability Redesign Study," retained in subcommittee files.]

Question 10

In its recent review of the Social Security Administration's practices in conducting CDI reviews, the General Accounting Office (GAO) found that beneficiaries who had been placed on disability because their condition "equaled" the listing are now being terminated because of a more narrow application of this concept. The GAO noted that in 1975, 44 percent of all awards were based on equaling the medical listings; in 1981, only about 9 percent of all awards were based on equaling the listings. Disability examiners told GAO that beneficiaries allowed in the past with multiple impairments are now being terminated because their impairments are being evaluated independently rather than looking at the total effect of the impairments.

(a) In the event that a beneficiary has two or three impairments, none of which independently meets the medical listings, as a matter of policy, what specific steps are disability examiners instructed to take in considering the cumulative impact of the impairments to determine if the listings are equaled? Please enclose copies of the POMS or other written memoranda which so instruct.

(b) What is the reason for the drop in the percentage of initial awards based on equaling the medical listings?

When an individual has multiple impairments and none of the impairments is found to meet the medical listings, the total medical findings for all impairments are then considered as to whether a listed impairment is equalled. For equivalency to be determined, the set of symptoms, signs, and laboratory findings for the individual's impairments must be determined to be equivalent, in terms of severity, to a listed set. If an equivalent listed impairment cannot be found, the most closely analogous listed impairment is used. The guides for this aspect of the disability determination process, which is the responsibility of the physician member of the DDS evaluation team, are described in POMS DI 2103, a copy of which is attached. This policy has remained essentially unchanged since 1965.

As noted by the GAO, the percentage of initial allowances determined to have equalled the listings declined from 1975 to 1981. Although we cannot precisely determine the causes of this decline, two changes may account for at least a large part of the drop. First, the quality assurance process became fully operational during that period, and this has resulted in better documentation which has caused claims that may have been previously allowed as equalling the listings to now meet the listings. Secondly, the listings themselves were revised in 1979 to reflect advances in medical treatment of some conditions and in the methods of evaluating certain impairments. To the extent that these changes incorporated into the listing certain criteria that previously were used to categorize impairments as equalling the listing, some awards were essentially moved from the "equals" category into the "meets" category. The percentage of initial allowances determined to have met the listings increased from 29 percent in 1975 to 65 percent in 1981. The percentage of all applications (allowances plus denials) determined to have met the listings increased from 13.5 percent in 1975 to 19.4 percent in 1981.

impairments which would be considered not severe, provided no disease or injury other than the condition which is described under these examples is demonstrated.

These examples provide criteria for evaluation of medical evidence for determining severity of an impairment. They do not represent a guide or directive to obtain or purchase the described evidence, unless that is considered necessary for proper case adjudication. For example, section 2102C.3.b. provides criteria for the evaluation of the results of arterial blood gas studies, when these have been obtained as medical evidence of record or the facts of the case otherwise dictate the need to obtain these tests.

1. MUSCULOSKELETAL

a. Osteoarthritis corroborated by X-ray findings, with symptoms of pain and stiffness of lumbar or cervical spine or major joints, and minimal abnormal findings on physical examination.
b. Traumatic fracture of a vertebral body, in the absence of metabolic bone disease, with loss of less than 50 percent of height of the vertebra without significant physical findings or neurologic abnormalities.
c. Status postsurgery for excision of lumbar disc without ongoing significant motor abnormalities or significant objective abnormal physical findings.

2. SPECIAL SENSES

a. Retention of best corrected visual acuity of 20/40 in the better eye (phakic) without significant restriction of visual fields.
b. Retention of visual field in better eye of a radius of 45 degrees or better (visual field efficiency of approximately 70 percent).

3. RESPIRATORY

a. Obstructive airway disease where $FEV_1$ or MVV is greater than values in POMS DI 2201, and there is no clinical evidence of impairment of gas exchange.
b. Diffuse pulmonary fibrosis where the arterial blood gas values do not meet the requirements of Listing 3.04, table III, at an exercise level of 25 ml. $O_2$/kg./min., or work equivalent.

4. CARDIOVASCULAR

a. Hypertension without significant organ damage, current or past.
b. History of chest pain without specific ischemic findings on ECG (rest and exercise), less than 50 percent narrowing on angiography, and without significant cardiomegaly.
c. Status postsurgery for peripheral arterial disease with palpable pulses below the femoral level and no intermittent claudication.

5. DIGESTIVE

a. Colostomy, uncomplicated, with proper function of the stoma and nutrition is adequately maintained.
b. Peptic ulcer, uncomplicated or with recovery from complications.
c. Chronic liver disease, in the absence of ascites, with total bilirubin less than 1.5 mg. per deciliter and serum albumin is 3.5 gm. per deciliter or greater.
d. Inflammatory bowel disease (regional enteritis, ulcerative colitis) in clinical remission for 12 months prior to adjudication.

6. GENITO-URINARY

a. Nephrotic syndrome, in remission, with persistent mild edema in which urinary protein excretion is less than 500 mg. per 24 hours and serum albumin is 3.5 gm. per deciliter or greater.
b. Chronic renal disease (other than nephrotic syndrome) in which the serum creatinine is persistently less than 3.0 mg. per deciliter (100 ml.), in the absence of clinical complications.

7. ENDOCRINE

Diabetes mellitus, adult onset, controlled on prescribed therapy, without significant end-organ damage or recent episodes of acidosis.

8. NEUROLOGICAL

a. Epilepsy with no major motor seizures for 12 months prior to adjudication.
b. Peripheral neuropathy or neuritis, due to any cause, with no significant motor or sensory loss.

9. MENTAL DISORDERS

IQ of 80 or greater in all major areas of intellectual functioning.

## 2103. Impairments Which Meet or Equal the Level of Severity in the Listings of Impairments

### *A. General*

A finding of disability will ordinarily be justified when the individual's impairment is one which is as severe as the examples contained in the Listing of Impairments. (See Appendix C). The Listing of Impairments contains over 100 examples of medical conditions which would ordinarily prevent an individual from engaging in any gainful activity. The purpose of the Listings is to insure that determinations of disability have a sound medical basis, that claimants receive equal treatment throughout the country, and that the majority of persons who are disabled can be identified. The level of severity described in the Listings is such that an individual who is not working and has such an impairment is considered unable to work by reason of the medical impairment. Thus, when an individual's impairment or combination of impairments meets or equals the level of severity described in the Listings, disability should be found on the basis of the medical facts in the absence of evidence to the contrary, e.g., the actual performance of substantial gainful activity.

### *B. Evaluating Medical Equivalence*

#### 1. EVALUATION

In determining whether an impairment is of equivalent severity to a listed impairment, the set of symptoms, signs and laboratory findings in the medical evidence supporting a claim must be compared with the set of symptoms, signs and laboratory findings specified for the listed impairment. For equivalency to be determined, the set of symptoms, signs and laboratory findings for an individual's impairment must be found to be equivalent, in terms of severity, to a listed set. Where the individual's impairment is not listed, the set for the most closely analogous listed impairment will be used. Where an individual has a combination of impairments, none of which meets or equals a listed impairment, the combination of impairments, each of which is manifested by a set of symptoms and relevant signs and/or abnormal laboratory findings, must be determined to be medically equivalent to the listed set to which it can be most closely related. In no case are symptoms alone a sufficient basis for establishing the presence of a physical or mental impairment.

#### 2. MEDICAL JUDGMENT REQUIRED

To emphasize that our decisions reflect a sound medical basis, the Regulations require that any decision as to whether an individual's impairment or impairments are medically the equivalent of a listed impairment shall be based on medical evidence demonstrated by medically acceptable clinical and laboratory diagnostic techniques, including a medical judgment relative to the question of medical equivalent furnished by one or more physicians designated by the Secretary. The DDS physician's documented medical judgment as reflected by his or her signature on the Form SSA-831-U5 (and SSA-833-U5) may, for purposes of initial and reconsidered determinations, be construed to meet this regulatory requirement.

## 2104. Types of Claims Determinable Only on the Basis of Medical Factors

### *A. Title II: Disabled Widow, Widower, or Surviving Divorced Wife*

The 1967 amendments provided benefits for widows, widowers, or surviving divorced wives whose physical or mental impairment or impairments are of a level of severity deemed sufficient to preclude an individual from engaging in any gainful activity. Such a level of severity is described in the Listings. In order to qualify for benefits a widowed person or surviving divorced wife must, therefore, have an impairment which meets or equals the level of impairment severity in the Listings.

### *B. Title XVI: Children Under Age 18*

Disability in children under age 18 will be determined solely in consideration of medical factors. A finding of disability may be made when the child's impairment or combination of impairments is as severe as the examples contained in the Listing of Impairments in Appendix C. When the specified criteria are met or equaled, disability may be established on the basis of the medical facts, in the absence of evidence to the contrary, e.g., the actual performance of substantial gainful activity.

## 2105. Interrelationship of Medical and Vocational Factors: Title II Worker or Childhood Disability Beneficiary/Title XVI Claimant Age 18 or Older

When a determination cannot be made in these types of claims on the basis of the medical factors alone—that is, when the impairment falls short of the level of severity depicted by the Listings, yet there is a significant limitation in the ability to perform basic work-related functions, the sequential evaluation process must continue with consideration of the vocational factors in the claim. A finding of ability to engage in any substantial gainful activity cannot be justified solely on the ground that the impairment does not meet or equal the level of severity depicted by the Listings. To support a disability determination in these cases, it must be established whether the functional limitations do or do not, in light of the vocational factors, prevent the individual from engaging in substantial gainful activity. In general, age, education, training, experience, and other individual factors will need consideration in any case requiring evaluation of facts beyond the medical report and work record.

A. Determination of the applicant's functional limitations requires medical review and assessment of his or her "residual functional capacity". See DI 2382.1 for discussion of the assessment of functional capacity.

B. Age—The term "age" refers to chronological age and the extent to which it affects the individual's capability to engage in work in competition with others. Reference sources and materials dealing with chronological age in terms of vocational relationship point to a direct relationship between age and the likelihood of employment. The data reflect employment problems developing at age 45 and the problem becomes significantly intensified at age 55. Thus, the Regulations reflect age 55 and over as advanced age representing the point when age could be expected to be an adverse consideration in determining an individual's vocational adaptability to work differing from that of his or her past experience. This designation of age is an expectancy only and not an arbitrary limit and may not be crucial in a particular case.

C. Education and Training—Education generally refers to formal schooling; training refers to skills and knowledge acquired on the job or through general experience in an industry or field of work. Both kinds of learning, or their lack, significantly affect ability to work, and must, therefore, be considered in evaluating

Question 11

In its recent study of the Social Security Administration's CDI reviews, the GAO also found that CDI cases were being developed and reviewed as if they were new claims. As a result, state agencies were gathering only current medical evidence (no more than 2 or 3 months old) and not considering information from treating physicians if older than that. What is your official policy on how Title II CDI's are developed and reviewed? What steps have been taken or guidance given to ensure that a historical medical perspective is considered in CDI reviews? Please elaborate on your testimony that the Social Security Administration was considering a requirement that all medical evidence for the past 12 months be considered in case reviews, and describe specific steps to test the appropriateness of the 12-month limit.

The development and review of a title II CDI are conducted by the disability determination service (DDS) of the State in which the individual resides. The first step in the CDI process is to request that the individual complete a questionnaire to describe the current status of the disability and to identify the treating physicians and other medical sources who have treated him during the past 12 months. The individual is also asked to sign a form authorizing the treating physicians and other medical sources to release current medical information to the DDS.

If there is no treating physician or medical sources, or if the medical evidence furnished by those sources is not sufficiently detailed to reveal the current status of the individual's impairment, the individual is requested to have a consultative medical examination, at SSA's expense. A local physician who has agreed to perform independent examinations for the State DDS performs the consultative examination.

All evidence obtained in the case is evaluated by physicians and trained disability examiners in the State DDS. In determining whether a disability is continuing or has ceased, all medical evidence received about the individual's medical condition is considered. If a decision cannot be reached on the basis of medical evidence alone, the individual's age, education, and work history are considered to determine whether the person can return to any past relevant work, or has the ability to perform other work that exists in the national economy. The individual is given a chance to submit additional evidence before final action is taken to terminate any benefits if the individual is found not to be disabled.

The DDS is required to make every effort to obtain medical evidence of record from the treating physician and other medical sources identified on the questionnaire as having treated the individual during the 12 months preceding the date that the individual signed the questionnaire form. This is the definition of "current" information. There is no 2 or 3 months' limitation. In addition, evidence from the prior file will be taken into consideration if it is material to the decision and would not have changed since the prior decision (e.g. an IQ score), or if the impairment is characterized by periods of exacerbation and remission, as discussed below.

SSA has implemented a requirement that all medical evidence cited for the past 12 months must be obtained and considered before preparing the CDI decision.

Previously, the DDS instructions only mandated securing evidence from medical sources listed on the questionnaire that was considered "pertinent" to the CDI decision. Teletype instructions (copy attached) to implement this policy were released on May 13, 1982.

A historical perspective beyond 12 months is not necessary in most CDI cases. The purpose of the CDI process is to determine the current medical condition of the beneficiary, not his condition at some point in the past. However, since some impairments, such as mental disorders, may have periods of exacerbation and remission, it may be necessary to develop and review the severity and duration of the impairment over a longer period of time. (This policy is discussed in the attached teletype.) The DDS secures additional development in these situations under the general directives provided for processing CDI cases under POMS reference DI 2864(c), Special Evaluation Considerations--Temporary Improvement: "Improvement that is only temporary does not warrant a finding that recovery has occurred. The probable duration of improvement and the prognosis should be carefully considered, particularly if the disease is characterized by periods of remission followed by relapse. All factors must be considered before it is concluded that recovery is not merely temporary."

**TELEGRAPHIC MESSAGE**

NAME OF AGENCY

PRECEDENCE
ACTION P
INFO.

SECURITY CLASSIFICATION
UNCLASSIFIED

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME
GIL LOGAN

PHONE NUMBER
4-9516

THIS SPACE FOR USE OF COMMUNICATION UNIT
RELEASED MAY 13, 1982

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:
FM: SSA OFFICE OF OPERATIONAL POLICY AND PROCEDURES

TO: ALL SSARCS

TO: ALL ARCSFOS

TO: ALL ARCSPGS

TO: ALL DDSS

TO: ALL PSCS/PSCTAS/DIO/ODO

TO: SSA OCO/OFO

TO: ALL ADS

TO: ALL FAOS/DPEQS/DPEQSOS

TO: SSA OA

TO: ALL OHA

INFO: ALL SSADOS/SSABOS/SSAGSS TBCS

IT 158-82 SJH-55

EMERGENCY DI/SSI INSTRUCTIONS NO. ODP-82-109 (75)

MANUALIZED INSTRUCTIONS WILL FOLLOW SHORTLY. DI 2800

SUBJECT: REVISED POLICY FOR DEVELOPING CURRENT MEDICAL EVIDENCE OF RECORD (MER) IN CDI CASES—ACTION

| PAGE NO. | NO. OF PGS. | SECURITY CLASSIFICATION |
|---|---|---|
| 1 | 3 | |

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : 1976 O-[illegible]

14

**TELEGRAPHIC MESSAGE**

NAME OF AGENCY

PRECEDENCE
ACTION:
INFO:

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

*THIS SPACE FOR USE OF COMMUNICATION UNIT*

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

EFFECTIVE IMMEDIATELY, THE FOLLOWING INSTRUCTIONS APPLY FOR THE DEVELOPMENT OF ALL MEDICAL CDI CASES:

1. THE DDS'S MUST REQUEST ALL MER FROM ALL SOURCES IDENTIFIED ON THE SSA-454AF4 THAT HAVE TREATED THE BENEFICIARY WITHIN 12 MONTHS FROM THE DATE OF THE SSA-454AF4. IF MER WITHIN THIS TIME FRAME CANNOT BE SECURED, THE DDS MUST DOCUMENT THE CASE FOLDER TO ESTABLISH THE DATES AND DESCRIPTION OF THE DEVELOPMENT ATTEMPTS.

THESE INSTRUCTIONS DO NOT CHANGE ANY STANDING POLICIES FOR THE DEVELOPMENT OF OTHER MEDICAL EVIDENCE THAT IS PERTINENT TO THE CDI. HOWEVER, THE REQUIREMENTS ABOVE FOR DOCUMENTING DEVELOPMENT EFFORTS ONLY APPLY IF THE MER IS WITHIN ONE YEAR FROM THE DATE OF THE SSA-454AF4.

2. THE [illegible] DECISION MUST BE DOCUMENTED WITH OBJECTIVE MEDICAL EVIDENCE THAT PROVIDES A SUFFICIENTLY COMPREHENSIVE AND CURRENT EVALUATION OF THE BENEFICIARY'S PRESENT ABILITY TO ENGAGE IN SGA.

SECURITY CLASSIFICATION

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STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : 1970 [illegible]

14-1

**TELEGRAPHIC MESSAGE**

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| NAME OF AGENCY | PRECEDENCE<br>ACTION<br>INFO | SECURITY CLASSIFICATION |
| ACCOUNTING CLASSIFICATION | DATE PREPARED | TYPE OF MESSAGE<br>☐ SINGLE<br>☐ BOOK<br>☐ MULTIPLE-ADDRESS |
| FOR INFORMATION CALL | | |
| NAME | PHONE NUMBER | |
| *THIS SPACE FOR USE OF COMMUNICATION UNIT* | | |

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

THE ASSESSMENT OF PROBATIVE RECENCY OF THE MER WILL BE DEPENDENT UPON THE TYPE OF IMPAIRMENT BEING EVALUATED. CONDITIONS WHICH HAVE PERIODS OF EXACERBATION AND REMISSION REQUIRE SPECIAL CARE TO ASSURE THAT THE DETERMINATION IS BASED ON ALL THE FACTORS IN THE CASE AND NOT ON A "SNAPSHOT" OF THE PERSON AT ONE POINT IN TIME. THE DDS PHYSICIAN SHOULD ASSURE THAT THE MEDICAL EVIDENCE IS RECENT ENOUGH AND COMPLETE ENOUGH TO SUPPORT THE DETERMINATION. AN INDEPENDENT CONSULTATIVE EXAMINATION MUST BE SECURED IF THE MER DOES NOT CLEARLY ESTABLISH IMPAIRMENT(S) SEVERITY AS OF THE DATE OF THE CONTINUANCE OR CESSATION DECISION.

NOTE: ANY SSA-454AF4 RECEIVED AND/OR REVIEWED SUBSEQUENT TO THE RECEIPT OF THIS TELETYPE MUST BE EVALUATED UNDER THESE REVISED PROCEDURES.

ASSOCIATE COMMISSIONER, OOPP

DESTRUCTION DATE:

FILE CODE: DI-12

SECURITY CLASSIFICATION

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STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : [illegible]

14-103

~~alleged by the individual. A consultative examination obtained to document the individual's allegation does not support the allegations. Cessation would be found as of the date indicated by the medical evidence of record.~~

### C. Special Evaluation Considerations

The following considerations assume particular importance in evaluating continuing disability cases:

#### 1. TEMPORARY IMPROVEMENT

Improvement that is only temporary does not warrant a finding that recovery has occurred. The probable duration of improvement and the prognosis should be carefully considered, particularly if the disease is characterized by periods of remission followed by relapse. All factors must be considered before it is concluded that recovery is not merely temporary.

#### 2. EXAMINATION REFLECTING RESULT OF REST

Conditions which become comparatively symptom-free after prolonged rest must be given careful consideration. Only where it can reasonably be expected that the capacity for SGA can be maintained under ordinary conditions of life in a work setting of the type for which the individual is qualified may a finding of cessation be made.

#### 3. MEDICAL REGIMEN

Generally, when an individual is hospitalized or a treating physician markedly restricts an individual's activities,

Question 12

In reviewing cases where there are conflicting medical findings between the treating physician's report and the consultative examination, how is that conflict resolved? Have disability examiners been instructed on which report should receive greater weight? When information is requested from a treating physician, what format is used and is the doctor asked for information in the clinical form which is best suited to determining if the medical listings are met or equaled?

The Program Operations Manual System (POMS) instructions do not permit assigning greater (or lesser) weight to any one report or piece of evidence. (A copy of these instructions was sent to you on May 10th in response to your April 27th request for information.) In arriving at a decision, the adjudication team is required to carefully weigh and evaluate all evidence in the file, whether such evidence was obtained from the claimant and the claimant's medical sources or from a consultative examination (CE).

CE's are purchased where necessary to clarify clinical findings, to obtain highly technical or specialized tests not otherwise available, where little or no evidence of record is available, or where available evidence is conflicting. All CE reports are reviewed for completeness, accuracy, internal consistency, and for consistency with other medical information in the file. Where deficiencies in such reports are identified, steps are taken to obtain the missing information or clarify inconsistencies, including purchase of additional examinations or tests where indicated.

When there are conflicting medical findings between the treating physician's report and the CE, and both reports are current, another CE is obtained. If the second CE agrees with the first, then the two CE's together will generally be given more weight than the treating physician's report. However, if the second CE supports the treating physicians's report , the treating physician's report will generally be give more weight since it, and not the first CE, is supported by additional evidence.

The POMS instructions emphasize that development should begin with the claimant's own treatment sources, particularly with respect to obtaining a history of the impairment, objective findings (signs, symptoms, and laboratory test results), and a description of the claimant's functional limitations and remaining capacities. There is no single format used for requesting medical information from a source. The format varies depending upon the individual case, and the request may be made by form letter, by a letter specifically geared to a claimant's impairment, or orally. Whatever format is used, it provides the source with a choice of several reporting options, including a narrative report, photocopies of office records, and documented oral reports. The format in which the information is received has no bearing on the State agency's ability to determine whether the medical listings are met or equaled.

Question 13

In the Social Security Administration's May 17, 1982, response to Subcommittee questions, the answer to question 4(c) indicated that the profiles for selecting cases in 1981 were also going to be used in selecting cases for review in part of 1982. However, selecting cases for the remainder of 1982 was to be based on a profile analysis of 25,000 cases and would entail a manual screening against a list of characteristics of permanent disabilities. Has that "profiling formula" been developed yet? And, if so, please provide a copy with explanations to the Subcommittee. In the manual screening of cases, has consideration been given to selecting cases for review which have the medical impairments with the greatest likelihood of improvement?

The "profiling formula" has been developed and will soon be run against the beneficiary rolls to determine the probability of whether the disability beneficiary is or is not disabled. The formula uses a number of specific variables (beneficiary characteristics) to determine the probability of the person's continuing disability. The variables include sex, number of auxiliary beneficiaries (if any), type of payee (self or other), 7 age groupings, year of current entitlement, workers' compensation offset (if any), and 3 total family monthly benefit groupings.

Based on the findings from the study of 25,000 cases, a specific probability-of-termination coefficient has been developed for each variable. (The findings are shown in response to question 9(d).) By combining the probability of cessation of each variable, a probability of cessation can be computed for each person getting Social Security disability benefits. Since dollar error is the target criterion, the final score in each case is computed by multiplying the probability of cessation by the family benefit amount to determine which cases should be selected first for periodic review. The cases with the highest scores will be selected for continuing disability investigations before cases with lower scores, but only after a separate screening is conducted to eliminate those cases involving impairments that have been classified as permanent.

A copy of the "profiling formula" is attached.

We did consider selecting for review cases with the greatest likelihood of recovery. A tentative list of impairments most likely to improve was drawn up by our Medical Consultant Staff. However, due to that staff's concern that recovery in cases beyond those diaried for regular review (see question 3) is difficult to predict, we did not pursue this approach to case selection.

## CDI Profiling Formula

The basic formula is

$$Z = b + b_1 x_1 + b_2 x_2 + \ldots + b_n x_n$$

where:

n is the number of variables, b is a constant equal to -.6959, and $b_1$ through $b_n$ are probabilities of cessation coefficients for each variable.

After a Z has been computed for each case, the probability of cessation, P, is computed as follows:

$$P = \frac{e^Z}{1+e^Z}$$

where e is a constant equal to 2.718.

Question 14

Please indicate the net savings (after increased staffing and processing costs) realized in FY 1981 as a result of accelerated CDI reviews and projected net savings for FY 1982, FY 1983, and FY 1984.

The accelerated review was begun in mid March 1981, so only a small number of cases can be counted toward reduction in benefit outlays in FY 1981. This is because the time needed to process cases, and the statutory provision for benefit payments in the month disability ends plus two additional months, resulted in the cessation of benefit payments in FY 1982 for many CDI reviews begun in FY 1981. Consequently the net for FY 1981 is probably a cost rather than a savings. However, it should be pointed out that administrative costs expended in 1 year, e.g., FY 1981, produce continuing benefit savings in future years; indeed, some of the FY 1982 and FY 1983 savings are due to CDI reviews made in FY 1981.

Estimated savings for FY 1982-84 are shown in the following table.

| Fiscal year | Estimated amount of reduction in benefit outlays 1/ Title II | Title XVI | Total (millions) | Estimated administrative cost, Title II plus 2/ Title XVI | Estimated net savings |
|---|---|---|---|---|---|
| 1982 | $370 | $ 2 | $ 372 | $156 | $216 |
| 1983 | 700 | 30 | 730 | 272 | 458 |
| 1984 | 970 | 115 | 1,085 | 3/ | 3/ |

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1/ Net effect, taking into account reconsideration and ALJ reversals.

2/ Breakout not available.

3/ Will not be available until the President's FY 1984 budget is submitted.

Ms. Greenberg's response to question asked by Senator Pryor

## Number and Types of People Who Could Be Involved in Processing a Continuing Disability Investigation (CDI) That Resulted In Cessation of Social Security Disability Benefits

The numbers and types of people involved could range from a minimum of eight nonprofessionals and two professionals (for a cessation based on a beneficiary's work) to as many as 124 nonprofessionals and 39 professionals in the very rare case where: (1) the beneficiary appealed the cessation all the way through all three levels of administrative appeal--reconsideration (recon), hearing, and appeals council; (2) a consultative examination (CE) was purchased by the government at the initial level, at recon, and at hearing, and (3) a quality assurance (QA) review was also done at each of the four adjudicative levels.

The attached chart shows the approximate number and types of people involved at each level of the process.

Number and Types of Employees Involved in CDI Cessations at Initial and Appellate Levels 1/

| | Initial CDI) | (Medical Initial CDI) | Recon | Hearing | Appeals Council | CE (Medical CDI) each level 2/ | QA (Medical CDI) each level 3/ |
|---|---|---|---|---|---|---|---|
| Mailroom | 2 | 5 | 5 | 4 | 6 | 2 | 0-2 |
| Clerical | 1 | 6-9 | 4 | 2-3 | 7-8 | 2-4 | 2-4 |
| Teletype | 2 | 2 | 5 | | 5 | 2 | 2 |
| Technical/Claims Rep | 1 | | 1 | 1 | | 1 | 1 |
| Typist | 1 | 1 | 2 | 1 | | 1 | |
| Receptionist | 1 | | 1 | 1 | | | |
| Examiner (P) | 1 | 2 | 1 | | | 0-1 | 1 |
| Physician (P) | | 1-2 | 1 | | | 1 | 1 |
| Supervisor (P) | 1 | 1 | 1 | | | 1 | 1 |
| Fiscal | | | | | | 1-2 | |
| Hearings Ass't | | | | 1 | | | |
| Hearings Clerk | | | | 1 | | | |
| Staff Attorney (P) | | | | 1 | | | |
| ALJ (P) | | | | 1 | | | |
| Appeals Council (P) | | | | | 2 | | |
| Total | 10 | 18-22 | 21 | 13-14 | 20-21 | 11-15 | 8-12 |

P = professional

1/ This chart is based on a "straight-line" approach, i.e., if multiple referrals through the same persons occur in the processing of the case, the people involved are counted only once. In many of the CDI's, the professional persons (P) processing the case do extensive work in developing the case, providing due process, obtaining medical evidence, assisting the claimant, etc. On the other hand, much of the clerical, nonprofessional contact with the case includes association, recording, mailing, etc., which takes a minimal amount of time.

2/ A CE could be purchased at the initial level, the recon level, or the hearing level, or at each of those levels.

3/ A QA review could be done internally by the State disability determination unit at the initial and/or recon level or by SSA's Office of Assessment at the initial and/or recon level.

STATEMENT OF SENATOR DONALD RIEGLE
HEARING ON SOCIAL SECURITY DISABILITY TERMINATIONS
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT
TUESDAY, MAY 25, 1982

WE MUST PUT A STOP TO THE UNJUST ASSAULT THE ADMINISTRATION IS WAGING AGAINST OUR NATION'S ILL AND DISABLED CITIZENS DEPENDENT ON SOCIAL SECURITY DISABILITY BENEFITS. URGENT CONGRESSIONAL ACTION IS NEEDED TO CORRECT THE PROBLEM OF SEVERELY DISABLED PEOPLE BEING THROWN-OFF DISABILITY ROLLS. MANY INNOCENT PEOPLE ARE NEEDLESSLY SUFFERING BECAUSE OF THE ADMINISTRATION'S ILL-CONCEIVED AND HARSHLY IMPLEMENTED PROGRAM TO WEED OUT THE RELATIVELY FEW INDIVIDUALS WHO ARE NO LONGER DISABLED.

IN 1980, AS PART OF LEGISLATION TO REFORM THE SOCIAL SECURITY DISABILITY PROGRAM, CONGRESS REQUIRED THAT ALL NON-PERMANENT DISABILITY CASES BE REVIEWED EVERY THREE YEARS AND ALL PERMAMENT CASES EVERY SEVEN YEARS. THE INTENT OF THE REFORM WAS TO SEE THAT INDIVIDUALS WHO HAD MEDICALLY RECOVERED, OR WHO HAD RETURNED TO GAINFUL WORK, NOT BE ALLOWED TO RECEIVE BENEFITS AND DRAIN AWAY FUNDS NEEDED FOR THOSE WHO ARE DISABLED AND UNABLE TO WORK.

THE ADMINISTRATION THEN ARBITRARILY SPEEDED UP THE REVIEW PROCESS MONTHS EARLIER THAN REQUIRED BY LAW. IN ADDITION, AND WITHOUT CONGRESSIONAL APPROVAL, THE CRITERIA USED TO DETERMINE DISABILITY WERE TIGHTENED FAR BEYOND WHAT THE LAW DESCRIBES AS DISABLED.

AS A RESULT OF THESE NEW STEPPED-UP PROCEDURES, THOUSANDS OF TRULY DISABLED PERSONS HAVE HAD THEIR BENEFITS SUDDENLY INTERRUPTED AND HAVE BEEN FORCED TO GO THROUGH THE LONG AND COSTLY REVIEW PROCESS. ALMOST TWO-THIRDS OF THE INDIVIDUALS WHO WERE CRUELLY THROWN-OFF THE DISABILITY ROLLS AFTER THE NEW REGULATIONS WERE IN EFFECT HAVE SINCE BEEN REINSTATED AFTER LENGTHY AND COSTLY APPEALS.

IN OUR SEVEN MICHIGAN REGIONAL OFFICES, THE NUMBER OF PERSONS WHO HAVE CONTACTED US ABOUT PROBLEMS IN THE SOCIAL SECURITY DISABILITY BENEFITS HAVE INCREASED BY AS MUCH AS 95% IN THE LAST YEAR ALONE. I HAVE BEEN CONTACTED BY HUNDREDS OF DISABLED INDIVIDUALS WHO ARE THREATENED WITH TERMINATION OR WHO ARE WORRIED THEIR BENEFITS WILL

BE TAKEN AWAY, EVEN THOUGH THEY REMAIN DISABLED AND UNABLE TO WORK.

JUST LAST MONTH FOR INSTANCE, I WAS CONTACTED BY THE DAUGHTER OF A MAN RECEIVING SOCIAL SECURITY DISABILITY. HE IS SUFFERING FROM SEVERE HEART DISEASE (INCLUDING TWO HEART ATTACKS) AND HAD BEEN SCHEDULED FOR TRIPLE-BYPASS HEART SURGERY. IN ADDITION TO THESE SEVERE PROBLEMS, THE MAN ALSO SUFFERS FROM A PEPTIC ULCER, HAS A GALL BLADDER CONDITION AND A DISEASED LIVER. STILL, HE WAS TAKEN OFF SOCIAL SECURITY DISABILITY. HIS DAUGHTER TOLD ME THAT HE IS TOO SICK FOR SURGERY TO CORRECT HIS PROBLEMS, BUT NOT CONSIDERED DISABLED BY THOSE REVIEWING HIS CASE. THERE ARE MANY MORE SIMILAR CASES COMING INTO OUR OFFICES.

CLEARLY, THERE IS SOMETHING DESPERATELY WRONG WITH THE ADMINISTRATION'S USE OF THE NEW REGULATIONS AND WITHOUT SWIFT ACTION THE SITUATION PROMISES TO GET WORSE.

I COMMEND THIS SUBCOMMITTEE FOR ITS CLOSE LOOK AT THIS SITUATION. I HAVE JOINED IN COSPONSORING SENATOR LEVIN'S BILL (S. 1944) TO HELP LESSEN THE SEVERE HARDSHIPS OF THE ADMINISTRATION'S ACTION AND TO MAKE THE PROCESS MORE CONSIDERATE AND HUMANE. UNDER THIS BILL, DISABLED INDIVIDUALS WILL CONTINUE TO RECEIVE THEIR SOCIAL SECURITY DISABILITY BENEFITS UNTIL THE APPEALS PROCESS IS COMPLETED.

THE CURRENT ADMINISTRATION OF THE SOCIAL SECURITY DISABILITY REVIEW PROCESS IS RESULTING IN CRUEL AND UNNECESSARY HARDSHIP FOR THOUSANDS OF DISABLED AMERICANS. WE MUST SEEK WAYS TO GET FEDERAL SPENDING UNDER CONTROL AND TO ELIMINATE WASTE AND FRAUD IN GOVERNMENT--BUT NOT AT THE EXPENSE OF THOSE DISABLED CITIZENS WHO HAVE EARNED AND ARE ENTITLED TO THEIR SOCIAL SECURITY BENEFITS.

UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D.C.

FOR EXPECTED RELEASE
Tuesday, May 25, 1982

# STATEMENT OF

GREGORY J. AHART, DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

ON

# SOCIAL SECURITY ADMINISTRATION'S PROGRAM FOR REVIEWING THE CONTINUING ELIGIBILITY OF DISABLED PERSONS

Mr. Chairman and Members of the Subcommittee, we are pleased to discuss the Social Security Administration's (SSA's) recent efforts in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, begun in March 1981, are commonly referred to as Accelerated Continuing Disability Investigations or ACDIs.

Because of the concerns expressed to us by several Members of the Congress over the medical conditions of the large numbers of beneficiaries being terminated from the rolls as part of the ACDI effort, in January 1982 we began to review SSA's policies and practices for conducting these investigations. ACDIs are performed by the various State Disability Determination Services (DDSs) following guidelines and instructions provided them by SSA. We have met with State officials and examiners in California, New York, Pennsylvania, and Ohio and examined approximately 100 case folders. In addition, we met with several administrative law judges and SSA officials.

We have identified a number of issues and problems with the current ACDI process that deserve attention by the Congress and SSA. First I would like to explain briefly the evolution of events which brings us to today's conditions; secondly, present some of our observations to date about the ACDI process; and also provide some suggestions for improving the process.

## BACKGROUND

In the past, SSA's primary means of identifying beneficiaries who may have medically recovered or regained the ability to work, and assessing their continuing eligibility for disability benefits, was through the "medical reexamination diary process". This process involved establishing a future medical reexamination date (diary) for beneficiaries with certain medical conditions that were believed to have a high potential for medical improvement. When the diary date matured, State agencies were to reevaluate the beneficiaries' medical condition. Investigations were also to be done when it was learned that a beneficiary had returned to work.

We reported to the Congress in March 1981 1/ that SSA had not adequately followed up on disability insurance beneficiaries to verify that they remain disabled. SSA had limited its investigations to a small percentage of beneficiaries, and even beneficiaries who met the criteria for reexamination had not always been investigated. Only about one of every five persons awarded disability was targeted for reexamination. The remainder, about 2.3 million persons, were never reexamined and would very likely remain on the rolls unless they returned to work, reached age 65 and converted over to the retirement program, or died.

Based on a nationwide sample case review conducted in 1979, SSA estimated that as many as 20 percent of the persons on the disability rolls who were never reexamined did not meet the disability criteria. SSA collected current medical evidence on about 3,000 cases and in some instances visited and interviewed beneficiaries in their homes. Using this evidence, SSA examiners and physicians determined whether or not the individuals were currently

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1/ "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," HRD-81-48, March 3, 1981.

disabled. Based upon this sample, we estimated that as many as 584,000 persons were not eligible for benefits costing the Disability Trust Fund over $2 billion annually.

Congressional concern over the high degree of selectivity in designating cases for medical reexamination and other inadequacies in the review procedures led to the enactment of Section 311 of Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. SSA officials estimated that this legislative mandate would require them to perform investigations on approximately 3 million cases over a 3-year period.

Due largely to an increased emphasis on cost-saving measures and to prepare for the massive workload anticipated in 1982, SSA began several projects aimed at improving the continuing disability process. SSA conducted several studies to help profile those beneficiaries with the highest likelihood of being found ineligible for disability benefits. Using these profiles, SSA began reexamining beneficiaries in March 1981 under the ACDI review. 1/

## ACDI CASE SELECTION AND WORKLOAD

SSA selected about 368,500 cases for investigation between March 1, 1981, and March 31, 1982. The States have completed

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1/Beginning January 1, 1982, the review was referred to as the "Periodic Review" because of the legislative mandate.

investigations and made decisions on about 189,500 cases, 1/ resulting in the termination of benefits in about 85,500 or 45 percent of the cases reviewed. This is in addition to the regular investigations of about 155,000 diaried cases per year that were determined to be subject to medical improvement.

During March and April of 1981, cases selected by SSA for investigation involved younger beneficiaries (under age 50) who were initially adjudicated in 1973, 1974, and 1975--years when the quality of decisions was believed to be at its lowest.

A different selection methodology was used beginning in May 1981. Cases were selected each month based on specific profiles using such characteristics as current age, total benefit payments, date of entitlement, numbers and kinds of auxiliary beneficiaries, and age at filing. SSA believed the profile selection technique would result in a more cost-effective use of resources than reviewing random groups of cases.

## ACDI TERMINATIONS-- WHY THEY ARE HAPPENING

As indicated by our March 1981 report, SSA was paying disability benefits to many persons who were not eligible for the program. This has been confirmed by the ACDI efforts to date. While we cannot quantify them, the ACDI/Periodic Review is identifying beneficiaries who

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1/ Another 30,000 cases have been reviewed by the States, but are considered "no decision cases" due to various reasons such as (1) being returned to the SSA district offices for further development of work related issues, (2) being sent to the wrong DDS, (3) individuals are deceased, and/or (4) having had an investigation already done in the last 12 months.

- --should never have been placed on the rolls initially, or
- --have medically improved, or
- --have died or returned to work, and otherwise would have gone undiscovered.

However, many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of SSA's decisions.

We will address these questions by looking at some of the factors causing these terminations (also referred to as cessations), including:

- --State agency medical development practices, and
- --the changed adjudication process and climate.

## State Agency Medical Development Practices

Much of the criticism brought to our attention about the ACDI effort has been directed toward the State agencies, and their procedures for medically developing ACDI cases. Specifically, concern has been expressed that State agencies are

- --terminating benefits without giving individuals adequate time to present medical evidence,
- --not obtaining or considering relevant information from treating physicians, and
- --overrelying on purchased consultative examinations which are sometimes too brief and possibly biased.

We did find some instances of poor medical development practices, as well as some decisions that were not adequately supported. We also question the State agencies' usual practice of gathering and evaluating only evidence that is from the most recent three months. We believe, however, that medical development issues are not unique to the ACDI/Periodic Review effort, and are not the primary cause of the high number of cases being terminated.

Results of case review

To address the issues raised about State agency medical development practices, we reviewed 98 ACDI cases in the 4 States we visited. Most of the cases were selected--either directly by us, or by State agency personnel monitored by us--as the State agency quality assurance units completed their technical review. This total also contained some cases (6) that had received a hearing before an administrative law judge. Our purpose in reviewing these cases was to look at the mechanics and timing of the medical development.

Forty-two of the 98 cases we reviewed, or about 43 percent, had resulted in cessations. Because of the small size of our sample, and the timing of our selection, we cannot project the results of our sample to what has happened in the ACDI/Periodic Review effort since March 1981. The table below presents some of the statistical information about the cases we reviewed.

| | Cessations | Continuances | Total |
|---|---|---|---|
| Number of cases | 42 | 56 | 98 |
| Average age of beneficiary | 43 | 45 | 44 |
| Average years on disability | 7 | 9 | 8 |
| Average case processing time 1/ (in days) | 127 | 83 | 102 |
| Percent of cases where claimants' physicians were contacted. | 69 | 74 | 71 |
| Percent of contacts responding to DDS | 90 | 81 | 85 |
| Percent of cases with consultative exam ordered. | 86 | 54 | 67 |

1/We counted from the date beneficiary was first contacted concerning the review (either by mail or phone) to the date the DDS physician signed the notice of decision.

The 42 cessations we reviewed averaged nearly 127 days from the time the beneficiary was first contacted about the review to the date of the DDS decision. This includes the 10 or more days allowed a beneficiary after being notified of the decision to submit any additional evidence. The shortest processing time we found for a terminated case was 34 days, the longest was 368. We found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence.

We found that attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. We found only a few instances where examiners did not request evidence from what we felt was a relevant source. While most sources did respond, we found a significant variation in quality, quantity, and objectivity in their responses.

It is difficult to evaluate to what extent attending physician data is considered in the States' decisions. Examiners complain that much of the information received from treating sources is too old to satisfy SSA's requirements, too subjective, too opinionated, and too sketchy to satisfy evidentiary requirements. Also, treating physicians often don't perform the kinds of tests required by the medical listings. Therefore, while it is clear that some portion of attending physicians' reports are not fully considered, we cannot determine the extent of this nor what impact this has on the final decision. We did see instances where attending physicians said their patients were totally disabled, yet the States discontinued benefits. However, these were invariably cases where the physicians submitted little objective evidence to support their conclusions, and hence, were of little use.

There has also been much concern expressed about the use--or overuse--of consultative examinations in connection with the ACDI/ Periodic Review effort. The 1981 consultative examination purchase rate in ACDI cases varied in the four States visited. We estimate it was 62 percent in Pennsylvania, 59 percent in Ohio, 58 percent in California, and 39 percent in New York.

Examiners say ACDI's generally require consultative examinations more often than other claims because many long-term disabled people haven't been to physicians recently. Ohio, for example, ordered examinations for only 30 percent of its entire caseload, but nearly 60 percent for ACDI's. During this limited study, we did not attempt to evaluate the appropriateness of the consultative exam purchase rate, nor the quality of the exams purchased. We do, however, plan to look at these and other issues pertaining to consultative examinations in the near future.

### ACDI/Periodic Review cases need special development

One aspect of State agency medical development that we feel needs to be changed is the practice of developing these ACDI/Periodic Review cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State agencies to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence--generally no more than 2 or 3 months old--and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also helps explain the high consultative examination purchase rate.

While the need for current evidence is obvious, we also believe there is a need for a historical medical perspective in these ACDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision on only the recent examination--often a purchased consultative examination--could give a false reading of that person's condition. This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments. For example:

> A 49 year old beneficiary in Pennsylvania was awarded disability insurance benefits in 1966 for schizophrenia. As part of the ACDI/Periodic Review, the State agency tentatively determined in March 1982 that his disablity had ceased. This decision was based solely on a consultative examination report that found him "fairly alert and responsive with schizophrenia controlled by medication". Following a due process procedure, however, the State agency reversed its decision in April 1982 because of information submitted by the beneficiary's treating physician. This report showed a history of repeated hospitalizations since 1950, emotional swings, and withdrawn and anti-social behavior.

Another tie between the initial claims process and the ACDI/Periodic Review efforts that might need change is the processing time goal. One measure of examiner performance in both initial claims and ACDI/Periodic Review cases is the percent of cases pending over 70 calendar days. While some examiners in the 4 states visited said they felt no undue pressure to move ACDI/Periodic Review cases, others said they are constantly aware of the time goal pressures. They felt it was unrealistic to be expected to develop these ACDI cases in 70 days. ACDI cases are often more difficult to develop than initial claims, and are more time consuming since they generally require more use of consultative exams.

We plan to evaluate this issue further to determine if it is causing examiners to rush their decisions. Because these beneficiaries are already on the rolls and receiving benefits, we see little imperative to reach decisions in a specific time frame.

## The Adjudication Process and Climate

A more significant factor in explaining the number of ACDI/ Periodic Review terminations is the way the medical evidence is evaluated to determine if eligibility for disability benefits continues. State agencies use the "sequential evaluation" process to determine if a beneficiary remains eligible. This process is a series of decisions based on medical and vocational evidence. Essentially, the State agency must determine if the beneficiary is working; if the alleged impairment is severe; if the impairment meets or equals the medical listings 1/; or, when the impairment is severe, but does not meet or equal the listings, if it prevents the beneficiary from doing his/her past work or any other work.

### Changes in the Evaluation Process

SSA--after almost a decade of prompting from the Congress, GAO, and others--has made major changes in the criteria and guidance used in the disability determination process. The criteria have become more explicit in certain areas, and in some areas they have become more stringent.

During the early and mid-1970s, those close to the disability program, especially State DDS administrators, voiced the need for revised medical listings. For example, in response to a March 1976 letter from the Chairman of the Subcommittee on Social Security,

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1/Medical evidence by itself is sufficient to establish that a person is disabled where it establishes the presence of an impairment included in the "Listing of Impairments" or an impairment(s) medically equivalent to a listed impairment(s).

House Ways and Means Committee, one State administrator wrote, "The listings are outdated, and desperately need revision." Another said:

> "...the listings are about 10 years out of date . . . for example listing 404, on myocardial infarction, is considered in error. A large majority of persons who have myrocardial infarctions, and survive, do return to work. Therefore, we may be allowing claims in which return to work is more than reasonable, in light of current medical practice..."

The medical listings were finally revised in 1979.

There were similar complaints about the need for improved, formal guidelines on evaluating vocational factors in the sequential evaluation process. In a 1978 Subcommittee report, Members of the Subcommittee on Social Security stated that they had

> "...for years urged the promulgation of more definite regulatory guidelines which would promote uniformity in decisionmaking and provide for enhanced administrative control of the program in this area. These proposed regulations spell out through a grid mechanism the weights to be given to the nonmedical factors..."

The vocational grid became part of the regulations in 1978.

During the mid-1970s, SSA also began to get more explicit about what it meant by a "severe" impairment. This was conveyed in written and oral policy instructions, training programs, and case returns to State agencies from SSA's quality assurance system. The result was an increase in the number of denials for "slight impairments".

All of these changes had a very definite impact on tightening up the "adjudicative climate". In response to a 1978 survey by the Subcommittee on Social Security, one State administrator said,

> "...I believe the primary reason for the recent conservative approach to disability evaluation is a direct result of the activities of the Subcommittee on Social Security, the General Accounting Office, and others involved in evaluating the effectiveness of the program. The Administration has apparently carefully considered all

> of the comments, inquiries, opinions, etc., and concluded that a 'tightening up' is desired. This view may be somewhat of an over simplication; but in the real world it is quite likely the root cause of the recent trends. In summary, I believe the 'adjudicative climate' has changed."

## Impact of Changes on the ACDI Beneficiaries

The changes to the sequential evaluation process and the adjudicative climate were evolutionary and were not developed to address specifically the ACDI/Periodic Review program. Because of the changes, however, many beneficiaries are being terminated. The changes in the medical listings in 1979 have affected some beneficiaries who previously qualified under the old listings, but do not meet the criteria of the revised listings. For example:

> A 51 year old beneficiary in New York was awarded disability benefits in 1975 following a myocardial infarction (heart attack). At that time, the medical listings only required evidence showing that the infarction occurred, and that the claimant had chest discomfort. The revised medical listings for heart impairments now require specific exercise test results or specific readings from a resting electrocardiogram (EKG). While the beneficiary's resting EKG readings in both 1974 and 1982 show similar abnormalities and he continues to suffer from angina (chest pain), his benefits were terminated because the EKG readings do not meet the requirements of the new listings.

Similarily, beneficiaries put on disability because their condition "equaled" the listings are now being terminated because of a more narrow application of this concept. In 1975, 44 percent of all awards were based on equaling the medical listings--instances where the impairment was not specifically described in the listings, but was considered equal in severity; or the combination of impairments was medically equal to any that were listed. In 1981, only about 9 percent of all awards were based on equaling the listings. Examiners have told us that beneficiaries allowed in the past with multiple impairments are now being terminated under the ACDI/Periodic Review effort because their impairments are being evaluated independently rather than looking at the total effect of the impairments. For example:

> A 50 year old beneficiary in Ohio suffered from hypertension, diabetes, and depression. Although none of these impairments met the specific listings, the claimant was awarded benefits in 1971 when their combined effect was considered. As part of the ACDI/Periodic Review, the State agency obtained evidence that contained essentially the same findings as that from 1971. However, the State agency now considered the impairments individually and terminated benefits because none met the specific listings.

The formalized vocational grid, now part of the regulations is also a factor in many terminations. In the mid-1970s many individuals whose impairments did not meet or equal the listings were allowed because of vocational factors (age, education, prior work experience)--even though there was little or no guidance available at that time on how to evaluate those factors. When reevaluating beneficiaries previously allowed for vocational factors, State agencies now terminate benefits in many of these cases because of the vocational grid. For example, beneficiaries 49 years old or younger with severe impairments that do not meet or equal the listings cannot be found to be disabled unless they are illiterate or unable to communicate in English. Most of the beneficiaries being terminated under this review effort are age 49 or younger.

### A New Decision

In summary, through the ACDI/Periodic Review process, SSA is reviewing a group of beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process. These are generally people who were led to believe that they were being granted a lifetime disability pension. Now, with no advanced explanation from SSA about the purpose, process, or possible outcome of the Periodic Review--they are subjected to a new decision, much the same as if they were applying for disability benefits for the first time. There is no presumptive effect given to the prior findings of disability, nor to the years that these individuals have been entitled to payments.

By getting a new decision these beneficiaries have several disadvantages. The decision is made using a newer, more objective, more stringently interpreted set of evaluation guidelines; and is made in a tougher "adjudicative climate." At the same time, these decisions are subject to the same inherent weaknesses that have always plagued the SSA disability determination process--subjectivity, and medical development of questionable quality and completeness.

Subjecting everyone to a new decision, also, has a major adverse impact on the group of beneficiaries who were placed on the rolls initially through the appeals process. Because of the historical differences in adjudicative criteria between the States and the administrative law judges (ALJs), many of these beneficiaries are now being taken off the rolls after reexamination by the same State agency that found them not disabled originally.

Since the State's original decision was "not disabled," a new decision by the State would generally be expected to have the same conclusion, particularly in light of the tightened disability determination criteria and adjudicative climate. Many of these individuals may be put back on after another appeal. 1/ We do not know how many cases are affected by this "merry-go-round" review, but the number could be quite large.

## MEDICAL IMPROVEMENT ISSUE NEEDS TO BE ADDRESSED

For the reasons discussed above, many beneficiaries whose conditions have not improved, or may even have worsened, are being told they are "no longer disabled," and are terminated from SSA's disability rolls. We believe the aspect of "no medical improvement" for a large percentage of the cessations during the last year accounts for much of the adverse publicity given the ACDI/Periodic Review process. This is not a new issue, but perhaps has been exacerbated by the large number of "non-diaried" cases examined by SSA during the last year.

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1/A recently completed study by SSA of over 3,600 decisions by ALJs highlighted clear differences in adjudicative criteria between the ALJs and the States as the major reason for the high number of decisions by ALJs to award benefits. For example, the ALJs awarded benefits in 64 percent of the 3,600 cases, whereas SSA's Office of Assessment, using State agency criteria, would have awarded benefits in only 13 percent. The study also highlighted the significant effect of a face-to-face meeting with the claimant.

During our limited case review, we did not attempt to quantify the number of cessations where there was no apparent medical improvement. However, a recent SSA study which formed the basis for the profiles used in the ACDI/Periodic Review, may provide some insight into this question. The study evaluated over 21,000 disability cases, and discontinued benefits in about 7,000 (33 percent). These cases were reviewed by SSA examiners and physicians for changes in the severity of the individual's impairments. Of the 7,000 cases where benefits were terminated, only 51 percent were determined to have medically improved. In 35 percent of the cases, benefits were ceased even though the severity of the impairments was judged to be the same as or worse than when benefits were initially awarded.

Under SSA's operating guides which have been followed by the States for approximately 4 years, disability is found to have ceased when current evidence shows that the individual does not meet the current definition of disability. SSA's policy states that it is not necessary to determine whether or how much the individuals' condition has medically improved since the prior favorable determination.

The possible need for legislation on the medical improvement issue was addressed by a 1976 staff report of the Subcommittee on Social Security, House Committee on Ways and Means, entitled "Disability Insurance--Legislative Issue Paper." SSA's policies since 1969 on CDI terminations had been that it was necessary to have documentation supporting an improved medical condition. The staff report pointed out that

> Revitalization of the CDI program can be carried out administratively, although if it is the subcommittee conclusion that the medical improvement requirement criteria should be altered, this may have to be done by legislation.

SSA dropped its former policy in May 1976 and until now there have been only a few court decisions on the issue. Those decisions have consistently argued for a return to some form of medical improvement.

The legislative history of the 1980 Amendments clearly indicates that the Congress was concerned about the individuals who have medically improved and remain on the disability rolls. However, it is not clear what the Congress' view was toward those who have not medically improved. Whether the Congress intended that all beneficiaries would be subjected to a "new determination," or whether it expected the earlier decisions to afford some presumptive weight, is an issue that we are still reviewing. Recent decisions in the U.S. Courts suggest that the Courts believe a degree of "administrative finality" or res judicata effect should prevail on these cases. Several class-action suits are pending which presumably will address this issue.

We believe the Congress should state whether cessations are appropriate for those already on the disability rolls who have not medically improved. There are other matters relating to the medical improvement issue that need to be considered also, such as how to deal with those on the rolls as a result of clear erroneous initial awards, and those that, despite no medical improvement, clearly come under a changed eligibility criteria or definition. We plan to work with the Subcommittee or other Members of the Congress in developing these matters further.

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We plan to continue reviewing several of the other issues discussed, and as this work progresses we will consider what actions SSA should take to improve the disability determination process and, specifically, the Periodic Review.

Written statement of Eileen P. Sweeney, staff attorney at the National Senior Citizens Law Center, submitted to the Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate (May 25, 1982)

I am Eileen P. Sweeney, a staff attorney at the National Senior Citizens Law Center (NSCLC). This statement is submitted in response to a request from Senators William S. Cohen and Carl Levin for such a statement.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and the Administration on Aging. Pursuant to the Law Center's Legal Services Corporation grant, we provide support services to legal services attorneys and paralegals throughout the country with respect to the legal problems of their elderly clients. Under the Administration on Aging grant, NSCLC is providing training and planning assistance to the states, and is developing strategies to resolve the legal problems of older people without the direct delivery of services. My responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

The problems created by the Social Security Administration (SSA) in the continuing disability investigations (CDIs) have reached a crisis level both in terms of the number of eligible disabled beneficiaries being cut from the rolls and in terms of the great emotional and financial hardship being imposed upon these severely disabled individuals. The incredible stories of human misery and suffering have appeared in the press across the country. Yet, not only has SSA not taken steps which would assure that disabled individuals are not cut, it continues to cut people daily. The cessation rate is between 45-47%. This year alone SSA will review 565,000 cases. Next year, it intends to review 800,000. Just between October, 1981 and May, 1982, SSA terminated the cases of 106,000 disabled individuals and their families. That number will continue to climb. While many of these people will eventually be returned to the disability program (the reversal rate on appeal is currently around 60%, although in some areas of the country it exceeds 80%), the damage to their lives created by the terminations is often irreversible. Families are losing their homes; unable to feed their children; some beneficiaries have taken their lives out of complete despair.

This is thus a very important hearing which presents the opportunity to investigate SSA's abuses of power and to consider solutions to the CDI crisis. This statement will begin with a general discussion of the CDI problem and discuss legislative changes needed to alleviate the crisis. The second section discusses some specific practices of the Social Security Administration which, in combination with the acceleration of the CDIs, or as a result of the CDIs, are clearly contributing factors in the crisis and which must be rectified.

## I. There must be a significant change in attitude in the administration of the CDIs.

Over the past few years, there has been a change in tone in the disability programs. Without much written instruction, all the signals are that state disability personnel should cut the rolls and keep them small. This has resulted in the termination of severely disabled individuals as well as the denial of new applicants. These signals include:

- requirements that SSA review allowances but not denials or terminations;
- excessive emphasis on speed to the exclusion of accuracy;
- as a corrollary, the failure to require states to assure that there is adequate evidence development;
- public discounting by SSA of the currently high administrative law judge (ALJ) reversal rates, arguing that it is the ALJs who are out of step with SSA and ignoring the growing problems at the state level;
- statements indicating that SSA is affecting budgetary savings in the disability program by terminating high percentages of allegedly non-disabled persons;
- indicating that the decision regarding which case to review is being based, not upon the likelihood of medical improvement, but upon the amount of the person's monthly benefit (the higher the benefit, the greater the chances for review).

The Reagan Administration is effecting the budgetary savings in the disability programs by cutting eligible people; exactly what Congress refused to allow them to do just last year. SSA has gone so far as to attempt through a variety of means to influence the outcome of decisions by ALJs. In one memo, dated May 7, 1981 (attached as "A"), the Associate Commissioner at the Office of Hearings and Appeals wrote to ALJs to express the concerns of the Commissioner and to inform ALJs of the "seriousness with which he views the SSA effort to thoroughly review those cases of individuals now on the rolls to determine whether they still fully meet all requirements for entitlement."

As witnesses have established, severely disabled individuals are being terminated without adequate medical evidentiary development and despite the fact that they are totally incapable of working. Often the only documents supporting these arbitrary and incorrect decisions are the inadequate reports of consultative examiners. In some cases, however, cases are being terminated even where the consultative examiner believed the person to be disabled.

All indications are that SSA is concerned with speed, not accuracy, in the disability determination process. That message has been made very clearly in the SSA regulations governing the federal-state relationship. 20 C.F.R. § 404.1601 et seq. These regulations do not even require that medical evidence be properly and fully collected. They do, however, set up numerous time frames with which the states must comply. While we agree that the states should be required to operate efficiently, timeliness is not beneficial to claimants and beneficiaries (in the CDIs), if it results in wholesale inaccuracies in decisions. It is similarly not cost-effective for SSA because claimants who do not believe they received full and fair consideration will appeal. There has been no effort to assure accuracy in the process.

The message must be changed. First, SSA should be required to amend its regulations to shift the emphasis to assuring accuracy in decision-making at the state level. To reinforce this shift, SSA should be required to review disallowances in the same fashion that they currently perform pre-effectuation review of allowances. It is not adequate to argue that the ability to appeal the denials is a self-policing mechanism rendering review of disallowances unnecessary. If that was true, SSA would currently be questioning the state's abysmal records rather than attacking the ALJs' high reversal rates. SSA simply does not view ALJ reverals as any reflection upon the accuracy of state agency decision-making. The result is that the easiest, least monitored, route for the states to take is to deny, regardless of the severity of the person's impairments.

In addition to requiring review of disallowances as well as allowances, we recommend that Congress take the following steps to change the message in order to assure that CDIs are performed properly and that claimants receive full protection from SSA and state agency abuses:

(1) Provide aid pending review in the Title II program through the ALJ level and that any payments received during the appeal process will not be treated as an overpayment should the person not ultimately prevail on the merits; and

(2) Amend the definition of disability to clarify that, before a person's disability benefits may be terminated, there must be a showing that his/her medical condition has improved or that the original decision awarding benefits was clearly erroneous. This last point is consistent with the rulings of numerous federal courts, which SSA has illegally chosen to ignore.

## II. Specific problems

### A. The reconsideration level of review

The reconsideration level of review is generally considered to be useless. In almost all states, it simply results in a rubberstamp approval of the original decision to deny or terminate benefits. It generally just serves to delay the time at which a person may first seek review before an autonomous administrative law judge. Many believe that the wisest solution to the problem would be to eliminate this level of review.

Representative Pickle has proposed steps to "strengthen" the reconsideration level of review in H.R. 6181 (formerly H.R. 5700). Unfortunately, the appellant will bear the entire burden of cleaning up this administrative nightmare. Nothing in that bill provides any incentives to either SSA or the states to properly adjudicate cases.

One provision of that bill will close the evidentiary record before a person ever appears before an administrative law judge. The vast majority of claimants are not represented at the reconsideration level. They are not familiar with the evidence required to support a finding of disability. Yet, they alone will bear the burden of assuring that the states improve their evidence development practices. This approach is unrealistic, unfair, and destined to fail.

First, it is unfair to expect that claimants will serve as police officers. The price which they pay is delay. Bouncing back and forth between the federal and state levels will add new elements of delay to the process. The ALJ will be required to review all of the evidence to determine if a remand is appropriate. Then, the case will return to the states, and then back to the ALJ. Very few cases are reversed at the reconsideration level. It is therefore likely that the case will return to the ALJ stage. Unrepresented disabled claimants and beneficiaries will be required to obtain all medical and vocational evidence on their own. The

ALJs will no longer be there to assist and, with rare exceptions, the state levels have not provided that assistance.

It is not realistic to expect that claimant-sought remands to the state agency level so that additional evidence may be introduced will result in a systematic clean-up of the reconsideration stage. Instead, it is more likely that the current problems will simply escalate: state agencies will deny cases, continuing to provide poor evidence development, knowing that claimants will appeal and, if they can obtain the evidence on their own, be forced to seek a remand. The Congress has already taken steps to remedy an analogous abuse in the SSA appeals procedure: prior to P.L. 96-265, the Appeals Council regularly failed to properly review appeals, knowing that they could easily obtain a court remand if judicial review was sought.

B. SSA "non-acquiescence" in court rulings

SSA has developed the nasty habit of ignoring rulings of the United States Courts of Appeals. They do so despite the fact that they have specifically informed the United States Supreme Court that their policy is the exact opposite. In Califano v. Yamasaki, 442 U.S. 682 (1979) the Secretary argued that certification of class action was not necessary because he followed rulings of the Circuit Courts of Appeals.*

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* "Restricted judicial review will not have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by] them within the jurisdiction of the courts rendering them." 442 U.S. at 699. In its Brief for the Petitioner in Yamasaki, at pages 68-69, the Secretary specifically stated:

(continued on next page)

Despite these representations to the Supreme Court, to which that Court specifically referred, SSA's true policy is that it will only follow decisions of the Supreme Court. A memo from Louis B. Hays, Associate Commissioner of the Office of Hearings and Appeals, to all ALJs, dated January 7, 1982, specifically states:

> "Frank Dell'Acqua [Deputy Assistant General Counsel, Social Security Division] stressed the point that the federal courts do not run SSA's programs, and that ALJs are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court. . ." (page 2)

But, despite the fact that the Secretary frequently loses cases in the Courts of Appeals, he rarely appeals. Conveniently, under his policy, because he does not appeal to the Supreme Court, there will not be a Supreme Court decision which he would have to follow. This means that he can simply award the named plaintiff benefits while otherwise ignoring the case.

A problem currently existing in the Ninth Circuit is an excellent, well-documented example of this incredible problem. In

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(continued from page 7)

> Contrary to the fears of the courts of appeals that have endorsed class actions under (§405(g)), that restricted version of judicial review permitted by that statute will have no detrimental effect on the efficient resolution of Social Security Act claims. When a statutory or constitutional issue is decided adversely to the Secretary in the course of judicial review obtained by an individual claimant, *the Secretary will either appeal or abide by the unfavorable ruling*. See *Philbrook v. Glodgett*, 421 U.S. 707, 720-772 (1975). Repetitious litigation will thus not be necessary in order to establish a general legal principal applicable beyond the confines of a particular case. (at this point, a footnote adds, "In some cases, however, additional litigation of an issue in additional jurisdictions is desirable. See pages 75-76, *infra*.) Stare decisis will impel the Secretary to follow statutory or constitutional decisions within the jurisdiction of the courts having rendered them. [Brief for the Petitioner (Secretary of the Department of Health and Human Services) at 68-69, *Califano v. Yamasaki*, *supra* (emphasis added)].

Finnegan v. Mathews, 641 F.2d 1340 (9th Cir. 1981), the Ninth Circuit ruled that the Secretary could not terminate the benefits of SSI disability recipients who had been "grandfathered" into the program from state disability rolls when the SSI program began, unless SSA established that either the "recipients' medical condition has materailly improved" or that there was "clear and specific error" in the original finding of disability. In other words, SSA can not apply its current regulations to cut a grandfathered person off as that would defeat the underlying purpose of the grandfathering language of the SSI provisions.

SSA did not like the Finnegan ruling. But, unlike other disgruntled litigants, it decided not to appeal to the Supreme Court and, instead, "non-acquiesced" in the ruling. SSA's thought processes here are particularly instructive. In a September 14, 1981 memo from Sandy Crank, Associate Commissioner for Operational Policy and Procedures, to Donald A. Gonya, Assistant General Counsel, (attached as Exhibit B), Sandy Crank outlined the following reasons for not appealing:

1) "...according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time." (page 3) Simply put, SSA had defended the Secretary's termination of benefits all the way through the Ninth Circuit, despite the fact that even they believed that Mr. Finnegan was disabled.

2) "Mistakes were made in the legal defense of this case before the Court of Appeals." (page 3)

He then recommened that SSA "non-acquiesce" in the court's order and wait for a case with poorer facts to take to the Supreme Court:

> "With a nonacquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not

> disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in Finnegan. The Office of Hearings and Appeals agrees with this course of action." (Id.)

So, in January, 1982, SSA issued Social Security Ruling 82-10c, "non-acquiescing" in Finnegan. And, as if that was not sufficient, on February 23, 1982, Louis B. Hays wrote another memo to all ALJs, specifically telling them that they were bound by the Social Security Rulings and were to ignore Finnegan even in "cases involving Court of Appeals for the Ninth Circuit." (Exhibit C)

This practice is clearly illegal. At least two circuit courts of appeals have struck a virtually identical practice of the National Labor Relations Board. See, for example, Ithaca College v. NLRB, 623 F.2d 244 (2d Cir. 1980); Allegheny General Hospital v. NLRB, 608 F.2d 965 (3d Cir. 1979). These cases hold that the agency is bound to follow the law of the circuit. Failure to do so results in the agency operating "outside the law." Allegheny General Hospital, 608 F.2d at 970.

SSA's illegal practice, just in the Finnegan case, resulted in the filing of additional litigation, all of which must be defended at government expense. In the state of Washington, a class of grandfathered SSI recipients who have been terminated have sued to enforce Finnegan. Siedlecki v. Schweiker, No. 82-6-R (W.D. Wash.) It is likely that other such cases will be filed in the states within the jurisdiction of the Ninth Circuit. In addition to needless governmental expense, SSA's failure to follow Finnegan has resulted in the cessation of hundreds, perhaps thousands, of SSI grandfathered recipients who are clearly entitled to benefits and who have no other means of support.

We stress that the Finnegan case is just one example of this problem.* Steps must be taken to require SSA and the Secretary of HHS to act within the laws both as it is written by the Congress and interpreted by the courts.

### C. SSA frequently issues orders which are inconsistent with the statute and SSA's own regulations.

SSA often utilizes the Social Security Rulings (SSRs), Program Operations Manual System (POMS), and a variety of other informational documents, to establish rules which are inconsistent with the Social

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*For other examples, compare: Levings v. Califano, 604 F.2d 591 (8th Cir. 1979), with Social Security Ruling (SSR) 80-11c; Boyland v. Califano, CCH Unempl. Ins. Rptr. ¶ 16,912 (6th Cir. 1980), with SSR 81-1c; Rasmussen v. Gardner, 374 F.2d 589 (10th Cir. 1967) with SSR 68-48c. This list is by no means exhaustive. Even where SSA has not issued a ruling refusing to follow a court's order, it has frequently done just that, ignoring others similarly situated until another court requires it to address the class aspects of the issue. For example, the district court's failure to certify a class in Wiesenfeld v. Secretary of Health, Education and Welfare, 367 F.Supp 981, 986-987 (D.N.J. 1973) (three-judge court), which invalidated a gender based classification in the Social Security Act, resulted in the need for additional litigation. First, the Secretary refused to provide relief to anyone but the named plaintiff until the Supreme Court issued its decision affirming the three judge court's ruling. 420 U.S. 636 (1975). Second, after that ruling, the Secretary applied the decision only prospectively to other individuals. At least two other suits were filed in order to obtain the benefits for the period prior to the Supreme Court's decision. See Crumpler v. Califano, 443 F.Supp. 342 (E.D. Va. 1978); Hurvich v. Califano 457 F.Supp. 760 (N.D. Cal. 1978). A similar situation arose after the Supreme Court struck down another gender-based classification in the Social Security Act. See Califano v. Goldfarb, 430 U.S. 199 (1977). Shortly thereafter, the Supreme Court summarily affirmed three district court rulings holding unconstitutional the same provision. At that point, the Secretary took the position that he would only pay benefits to those few individuals injured by the provision who had received a final adverse decision from the Secretary and also instituted suit against the Secretary pursuant to 42 U.S.C. § 405(g). Wright v. Califano, 603 F.2d 666, 668 (7th Cir. 1979). It was not until the Seventh Circuit's ruling in Wright, supra, that the Secretary finally agreed to pay all the benefits due to all individuals who had been injured by the provision held unconstitutional in Goldfarb who were members of the certified class in Wright.

Security Act and Social Security's own regulations. In the context of the CDIs, the result has been that thousands of beneficiaries' cases are being illegally terminated, only to be later restored by the ALJs, who do follow the federal statute and regulations.

Examples of the problem reflect its enormity:*

1. 20 C.F.R. §416.929 requires that consideration be given to a person's pain in assessing his/her disability. This is supported by numerous court decisions. Yet, SSA deleted the instructions to consider pain from the POMS, which is followed by the state agencies, explaining that "deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed." Section 2205.

2. 20 C.F.R. §404.1545(a) requires that in assessing a person's residual functional capacity (RFC) to work, all impairments will be considered. With regard to mental impairments, 20 C.F.R. §404.1545(c) provides:

   > When we assess your impairment because of mental disorders, we consider factors such as your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting.

   Obviously, as the Secretary has recognized, these factors are critical in assessing the ability of the mentally disabled person to work. Yet, via an "informational digest", SSA has eliminated consideration of mental impairments from the RFC evaluation. The result has been the wholesale termination of severely mentally disabled people from the rolls based upon findings that they have the residual functional capacity to work.

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*An excellent review of these problems has been written by Daniel P. Melcher, Legal Aid Society of San Diego, San Diego, California, April 19, 1982.

As noted in the earlier discussion on "non-acquiescence", SSA has refused to follow the Finnegan ruling that there must be evidence of medical improvement or a showing that the original decision of eligibility was clearly erroneous before a disabled person grandfathered into the SSI program may be terminated. Using a Social Security Ruling, SSA has ordered the ALJs to ignore Finnegan. SSR-82-10c. It should be noted that the Rulings are not statutorily recognized but are, instead, a creation of the Secretary which he has, by virtue of one regulation, made binding upon ALJs while avoiding public notice and comment. 20 C.F.R. § 422.408

It is critical that the current system of dual rules be changed. However, any change should assure that all binding rules be subject to public notice and comment. Under a provision of H.R. 6181 (Section 7) reported by the House Ways and Means Committte last week, the Secretary would be required to assure that all levels of review follow the same standards. However, there is no mention of public notice and comment. The Commissioner has indicated that he will utilize the SSRs to create such rules. The bill would permit him to utilize even the POMS. The provision should not be enacted. It is critical that the disability determination process and the standards utilized therein be accessible to the public and subject to public comment. The only binding rules should be those which are properly promulgated in accordance with the Administrative Procedure Act. SSA's unauthorized practice of "non-acquiescing" in judicial decisions it disagrees with has effectively insulated it from fully complying with various court rulings, despite SSA's failure to appeal the decisions with which it disagreed. The Social Security Rulings, SSA's vehicle for "non-acquiescing," should not be accorded the weight suggested by the proposed provision. Rather, Congress should examine SSA's policy of "non-acquiescence" and consider its appropriateness in the overall administrative review scheme. Similarly, changes in the POMS are not issued for public comment. The effect of Section 7 will be to encourage SSA to avoid the regulatory process, just amending the POMS. As mentioned earlier, SSA already tends to issue POMS sections long before even proposed regulations are issued. This practice should be discouraged rather than encouraged. Further, the public comment process is extremely important. Often it is the only means available to claimants and their representatives to express their concerns. Finally, access to the POMS is limited to SSA offices, unlike the Code of Federal Regulations, rendering it more difficult for claimants and their representatives to remain up-to-date on its contents.

### D. Consultative examinations purchased by SSA are generally inadequate.

The federal government paid approximately $137,400,000 for consultative examinations in 1981.* It is therefore reasonable to assume that SSA should be expecting to get something useful for its money. Further, as the consultative examiner's report is often the only document which supports the arbitrary and incorrect terminations in the CDIs, it is critical to the disabled individual that they be performed properly and that reports accurately and completely describe their medical condition.

The Oversight and Social Security Subcommittees of the House Ways and Means Committee have held two hearings specifically addressing the problems created by "volume provider" consultative physicians, those who do a substantial amount of business with state disability units.** While the problems are exacerbated by the bulk nature of their business, the underlying theme of the need for effective regulation and monitoring by SSA exists regardless of the number of referrals.

Given the emphasis on time and the incredible backlog created by the CDIs (as well as the acceleration of the CDI process), it is not at all surprising that the states place a premium upon a physician's ability to provide reports in the shortest time possible.

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* Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, September 18, 1981, House Ways and Means Committee, Serial 97-27, page 12.

** In many states, the volume or bulk providers are churning out report after report, denying disabled individuals the benefits to which they are entitled. In Tennessee, for example, the volume provider denies disability at a higher rate than the average. At the September 18, 1981 hearing, Herbert L. Brown, Director, Disability Determination Section, Tennessee, stated that, in a sample review, Thurman and Thurman denied 82.5% while the state average was 73%. "Volume Providers of Medical Examinations for Social Security Disability Programs," Serial 97-27, page 92.

Two aspects of this are particularly disturbing. First, time appears to take priority over all, or almost all, other relevant considerations in making the referrals to consultative physicians. Second, the volume providers, doing all or almost all of their business with state DDS units, recognize this need and, with their word processing equipment and often questionable practices, are able to capitalize upon it, to the detriment of disabled individuals.

The states' preoccupation with timeliness is reflected in the material which SSA provided to the Oversight and Social Security Subcommittees of the Ways and Means Committee set forth at Ways and Means Committee Print, Serial 97-27, pages 25-34. Timeliness of reporting is often cited as a basis for identifying a referral while no reference is made to identifying the physician(s) whose specialty renders him/her in the best position to properly assess the claimant's condition.

[In some areas of the country, the administrative law judges simply ignore the consultative reports because their experience with the particular provider(s) has taught them that their reports are useless and unreliable. Given the current abuses of some consultative physicians, this is as it should be. However, it is critical that the cost implications be recognized. Because SSA has failed to regulate consultative physicians, it is throwing money away just so that it can assure that there is a piece of paper in the file. If the reports are so useless as to be ignored, they should not be purchased.] It is critical that SSA be required to issue regulations which set forth minimum requirements for consultative physicians. Factors which have been suggested include:

1) a limit on the number of examinations which may be scheduled per hour and per day;
2) minimum competency requirements for technicians, aides and paramedics who assist in performing the exams;
3) periodic checks on the equipment used in consultative exams;
4) a requirement that the consultative physician personally author and sign the report and the physical capacities evaluation;
5) a requirement that the state unit consider paying for a consultative exam performed by the claimant's treating physician before considering a referral to a non-treating physician;
6) a requirement that the State Disability Determination Unit establish contacts with community health clinics to assure that more consultative exams are performed locally instead of by volume providers;
7) require written documentation as to how much time the consultative physician spent examining the claimant;
8) require written documentation that the laboratory tests and x-rays were actually done.

In addition, (9) the consultative physician should be required to have familiarized himself/herself with the various test results and to have personally read all x-rays prior to completion of the report.

10) The regulations should also establish some mechanism for assuring that claimant complaints regarding consultative physicians are investigated and resolved.

## E. Accessibility of hearings

Briefly, SSA is making it tougher for appellants to appear at hearings before ALJs. First, the Office of Hearings and Appeals has limited the ability of ALJs to travel to satellite locations. Unless the location is over 75 miles from the appeals office, the claimant must travel to the appeals office. See January 7, 1982 memo of Louis B. Hays, page 2-3, attached as"D." This is true despite the fact that there may be more than one large concentration of population in the 75 mile area, thus creating significant hardships for large numbers of people. For example, OHA no longer holds hearings in Colorado Springs. Appellants must all travel to Denver.

Needless to say, there is no statutory or regulatory authority for the 75 mile rule. It is an arbitrary limit which far exceeds reasonable expectations of the ability of severely disabled people to travel. But, OHA may force some appellants to travel even further. The Hays memo indicates that OHA "will also encourage giving claimants the option to travel to the hearing office for their hearing, even if the distance is more than 75 miles." *Id*. page 3.

The problem is further aggravated by SSA's failure to implement those portions of P.L. 96-265 which require that SSA reimburse appellants for the costs of travel. The provisions took effect in 1980. The only activity from SSA has been a notice of intent to publish proposed rules which appeared on January 15, 1981. 46 Federal Register 3537.

Unfortunately, Congress may soon incorporate these inequities into the reconsideration level. In H.R. 6181, the evidentiary record will be closed after a hearing is held at the reconsideration level. As reported at the Ways and Means Committee mark-up, either the bill or the report will indicate that the state reconsideration level hearings must be as accessible as ALJ hearings. In a time when OHA is rendering ALJ hearings increasingly inaccessible, it will be disastrous for that scheme to be looked to as the standard for the state level.

F. SSA notices regarding its change of policy on the creation of overpayments in the CDI process.

On March 16, 1982, Commissioner Svahn informed the Social Security Subcommittee of the House Ways and Means Committee that SSA will no longer determine that a person has been overpaid when the date of disability cessation is earlier than the date of the notice of cessation. SSA later issued instructions requiring staff to assure that this change in policy is applied to all cases in the administrative appeals pipeline.

Unfortunately, the good news ends there. On April 15, 1982, Philip T. Brown, Chief ALJ, sent a memo to all ALJs. (Attached as "E.") In that memo, Mr. Brown informed the ALJs that in any case in which they change the cessation date (in order to eliminate the overpayment) but hold that the appellant is not disabled, they are to issue form HA-L502 "Notice of Favorable Decision." ALJs are issuing such notices. See "F", attached.

Many SSI and OASDI recipients are unsophisticated and often have attained relatively low educational levels. For this population, the notice being sent is especially cruel: they will read the first line and, in many cases, will not proceed to read the rest. Probably not aware of SSA's new policy on overpayments, they will justifably believe that they have been found disabled and will forego filing an appeal within the 60 day period.

OHA is also issuing a second, equally obnoxious, notice in cases where the appeal has been filed but the hearing before the ALJ has not yet been held. (See "G") SSA is eliminating the overpayment before the hearing and then sending a notice to the appellant which encourages the unknowing appellant to withdraw the appeal, despite the fact that withdrawal will result in forfeiture of the right to a hearing on the issue of disability. While the identifying information has been deleted from the attached notice, the portion of the form to be detached and returned already had the appellant's name and social security number typed in. In order to withdraw, all he has to do is sign the form and return it "in the enclosed postage free envelope." Nothing in the notice tells the person that no action has been taken on the issue of termination of disability benefits.

Both of these notices raise serious questions about the Secretary's intent. Waiver of the overpayment is meaningless when compared to the loss of the person's ability to appeal the termination decision. This is particularly true now when ALJs are reversing 59% of these arbitrary terminations.

The problems here can be easily solved. The Secretary should take the following steps:

1) Straightforward notices of denial should be sent where the ALJ upholds the state's termination.
2) Decisions to waive overpayments should not issue before the date of the hearing.
3) All appellants who received form HA-L502 improperly should be sent a second notice which clearly sets forth the denial of disability and provides for a full 60 day period in which to appeal from that second notice.

4) The appeals of all appellants who received the pre-hearing notice and returned the request to withdraw should be immediately reinstated.

Conclusion

The incredible problems in the administration of the Social Security disability program cry out for Congressional attention. Steps should be taken to remedy this crisis before the 565,000 people this year and the 800,000 next year are all subjected to similar practices.

Thank you for this opportunity to comment.

analyst

# MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TO : Chief and Deputy Chief Administrative Law Judges
Regional Chief Administrative Law Judges
All Administrative Law Judges

DI-12
DATE: MAY 07 1981

[illegible]
SGP-2
300(81)

FROM : Andrew J. Young
Associate Commissioner
Office of Hearings and Appeals

Andrew J. Young

RECEIVED
MAY 19 1981
OHA, PASADENA

SUBJECT: Accelerated CDI Program - Impact on Office of Hearings and Appeals - INFORMATION

As you know, the Social Security Disability Amendments of 1980 (P.L. 96-265) provide for the review, effective January 1982, of all Title II disability beneficiaries at least once every 3 years unless their disabilities have been declared permanent. Beneficiaries with permanent disabilities must be reviewed less often, i.e., every 5 to 7 years. This review was mandated by statute as a result of Congressional concern about the lack of a consistent, large scale effort by SSA to reexamine the cases of individuals who have been on the disability rolls for many years.

Studies completed by the Social Security Administration and others over the last two years - and most notably the recent General Accounting Office study - suggest that there may be significant numbers of people on the disability rolls who do not currently meet the requirements of the law for continued entitlement. In view of these findings, a major policy decision has been made to review as many cases as possible on the SSA rolls. The Administration is not waiting for the periodic review provisions of the new law to become effective and, indeed, has already begun this review in conjunction with the state Disability Determination Services.

I have been asked by the Commissioner to express to you his concerns about the findings of the recent studies and the seriousness with which he views the SSA effort to thoroughly review those cases of individuals now on the rolls to determine whether they still fully meet all requirements for entitlement. I share the Commissioner's concerns.

## Impact of Effort on OHA

It is expected, if the GAO findings are reasonably reliable, that the DDSs will determine, at initial and/or reconsideration levels, that cessation of benefits is warranted for a large number of disability beneficiaries. It is to be further expected that such individuals will avail themselves of their statutory rights to challenge such cessations by requesting hearings before our administrative law judges, probably in ratios at least equivalent to that prevailing for initial benefit denials (now running at over 70 percent).

We do not know the exact volume of the hearing workload which will result from cessation determinations made during the accelerated CDI initiative, but it is one which must be handled. The new regulatory standard for assessing such cases, as you know, is no longer whether there is demonstrated medical improvement but rather whether the beneficiary, on the basis of current evidence, is disabled or not under the adjudicative standards that govern disability adjudication (see SSR 81-6, January 1981).

This is a serious effort designed to assure, in the traditions of prudent and sound public administration, that benefits are being paid only to those individuals fully and legally entitled to them. Since the accelerated review schedule must first pass through DDS processing, we anticipate that the initial impact from the CDI initiatives will likely first be felt in OHA in August or September of 1981 with the full impact not expected felt until FY 82.

DEPARTMENT OF HEALTH & HUMAN SERVICES

cc: DLS

Memoran

OPI
OSC
OAC
DA

Date . SEP 14 1981

From: Associate Commissioner
for Operational Policy and Procedures

Subject: Federal Title XVI Litigation--Terry Finnegan v. Matthews (U.S. Court of Appeals, Ninth Circuit, 641 F. 2d 1340, April 16, 1981)--INFORMATION

To: Donald A. Gonya
Assistant General Counsel

## ISSUE

This is in response to your request for my recommendation on whether we should seek an appeal to the Supreme Court in Finnegan. I believe that we should not petition for a writ of certiorari in this case, but, instead, should publish a ruling of nonacquiescence. The issue in Finnegan is whether the Social Security Administration (SSA), when attempting to remove a grandfathered Supplemental Security Income (SSI) disability recipient from the rolls, must show that there has been "a material improvement in his medical condition" or that there was "a clear and specific error" made by the State in its original determination of disability under the former State program.

## BACKGROUND.

The plaintiff, Terry Finnegan, who had been receiving State disability welfare payments since 1972, was grandfathered into the SSI program in 1974. Following a continuing disability investigation, he was informed that SSI payments would cease because he was no longer disabled under either the Federal SSI program or the Washington State disability program which was in effect prior to January 1, 1974 (the effective date of the SSI program). SSA's decision to terminate Finnegan was affirmed by the U.S. District Court for the Eastern District of Washington. On April 16, 1981, the U.S. Court of Appeals for the Ninth Circuit reversed the decision of the district court and thereby reversed SSA (see tab A). In reversing SSA, the Court of Appeals found that the termination of Finnegan's benefits was improper because there was "no material improvement in Finnegan's medical condition or clear and specific error in the prior State proceedings."
On June 25, 1981, the Court of Appeals denied SSA's request for a rehearing in Finnegan.

Section 1614(a)(3)(E) of the Social Security Act is the "grandfather" clause which provides for the continued payment of SSI to a converted individual who "is permanently and totally disabled as defined under a State plan . . . so long as he is continuously disabled as so defined." Section 1614(a)(3)(E) also limits eligibility for conversion to those individuals

Second Floor
Hoge Bldg
Seattle WA 98104

B, P. 1

who in December 197[illegible] were receiving aid for their total disability under a State plan approved under title XIV or XVI, as in effect for October 1972. Individuals eligible for conversion must also have received aid for at least one month prior to July 1973. These limitations to the grandfather clause were added as a "rollback" amendment to prevent States from transferring their welfare recipients onto the disability rolls in anticipation of the Federal takeover.

## DISCUSSION

SSA interprets section 1614(a)(3)(E) to mean that individuals who satisfy its criteria are grandfathered into the SSI program and are thereby protected from termination of SSI benefits so long as they continue to meet the Federal or the former State plan definition of disability. When a continuing disability investigation is conducted to determine whether a grandfathered SSI recipient is still disabled as defined by the State plan, State statutes and regulations are available and used by disability examiners and Administrative Law Judges (ALJs) in adjudicating cases.

In Finnegan, the Court of Appeals rejected SSA's interpretation. According to the Ninth Circuit:

> "An ALJ's inquiry must . . . focus on whether a clear and specific error had been committed during the previous State determination of eligibility and on whether the recipient's medical condition has materially improved. Absent a finding of clear and specific error in the earlier determination a recipient must logically have been 'disabled under a State plan;' absent a finding of subsequent material medical improvement a recipient must logically still be disabled 'as so defined.'"

In essence, the Finnegan court's order means that ALJs should not rely on their own interpretations of the prior State plans, but rather that they should weigh the current evidence against the State's initial disability determination to decide whether there was "specific error" or whether the recipient's "medical condition has materially improved."

SSA would face problems in complying with the court's order because in many conversion cases the evidence with which convertees were initially allowed is either incomplete, unavailable, or no longer in existence. In the case of Finnegan, it would be possible to comply with the court's directive because the record contains a copy of the State's initial disability determination in 1972, as well as pertinent medical evidence for that period. In many conversion cases, however, complete documentation regarding the State's initial finding of disability is unavailable. It would be difficult in those cases to show either improvement or error.

While we strongly disagree with the court's rationale and would face major problems in implementing the court's order generally, there are significant weaknesses in the Finnegan case. Mistakes were made in the legal defense of this case before the Court of Appeals. It seems that the U.S. Attorney's office defended this case without the advice of the Department of Health and Human Services' legal counsel and misinformed the court about SSA's position with regard to grandfathered SSI recipients.

In addition, there has been no improvement in Finnegan's medical condition since the original State allowance and according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time. Since the facts indicate that the State determination was one of judgment, and since we know that Finnegan has not improved, we believe that the Supreme Court might not think it appropriate for SSA to substitute its judgment for that of the original adjudicator.

RECOMMENDATION

I recommend that certiorari to the Supreme Court not be sought in Finnegan. Although the court's order is based on a faulty understanding of the continuing disability process, the standards applied by SSA and the practical problems in complying with the more restrictive standard erected in Finnegan, we believe that the factual situation in Finnegan makes it inappropriate for review of these issues by the Supreme Court.

If the Solicitor General decides not to seek certiorari, we believe it is critical that SSA publish a ruling of nonacquiescence in order to limit the holding of the Ninth Circuit to Mr. Finnegan. With a nonacquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in Finnegan. The Office of Hearings and Appeals agrees with this course of action.

/s/ Sandy Crank

Sandy Crank

Attachment:
Tab A - Circuit Court Decision

cc:
Office of Disability Programs
Office of Hearings and Appeals
Office of Regulations (Rulings)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to: SGP-2

# Memorandum

22(82)
CL-19

MAR - 1 1982

**Date:** FEB 23 1982

**From:** Associate Commissioner
Office of Hearings and Appeals

**Subject:** Ruling of Non-Acquiescence-Continuance or Cessation of Grandfatheree's Disability - INFORMATION

**To:** All RCALJs
All ALJICs
All ALJs

On April 16, 1981 the United States Court of Appeals for the Ninth Circuit issued a decision holding that Supplemental Security Income (SSI) benefits based on disability to a claimant who had been converted from the State welfare rolls to the Federal SSI program in January 1974 (grandfatherees) could not be terminated unless SSA showed that there was either a material improvement in the claimant's medical condition or a clear and specific error in the prior State determination.

I want to draw your attention to Social Security Ruling SSR 82-10c in the January 1982 quarterly Rulings publication, indicating the Social Security Administration's non-acquiescence in the Court's decision. Under SSA policy, it is not necessary to show that there has been improvement in the claimant's condition or any error in the prior State determination for benefits to be ceased. It is SSA's position that a grandfatheree's SSI benefits based on disability may be ceased when the claimant's disability, as shown by the current medical or other evidence, does not meet the criteria of the appropriate State plan or the Federal criteria—i.e., the impairment is such that the claimant is able to engage in substantial gainful activity (20 CFR 416.994).

Although the ruling addresses only criteria for ceasing disability for a grandfatheree, you should be aware that the criteria for ceasing benefits based on disability also apply where the claimant is a title II or SSI non-grandfatheree beneficiary. This basic policy is reflected in SSR 81-6 (January 1981, p.27).

Social Security Ruling SSR 82-10c is binding on all components of SSA including administrative law judges and the Appeals Council (20 CFR 422.408). SSA's policy must be followed in cases involving the issue of cessation of disability, including cases involving claimants who reside within the jurisdiction of the United States Court of Appeals for the Ninth Circuit.

Louis B. Hays
Louis B. Hays

cc:
Office of Appeals Operations
Co-Deputy Chairperson, Appeals Council

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED FEB 1 1982

Refer to SGA

**Memorandum**

Date. JAN 7 1982

From. Associate Commissioner
Office of Hearings and Appeals

Subject ALJ Policy Council Meeting

To All Administrative Law Judges

I would like to share with you a summary of the topics and discussion at the meeting of the ALJ Policy Council held in Arlington, Virginia on December 2 and 3, 1981. The meeting was attended by Kathleen R. Dacey (Boston), Irwin Bernstein (Jamaica), Moses Thompson (Montgomery), Gordon L. Sroufe, (Columbus), John M. Slater (Tulsa), Edwin W. Canter (Brentwood), Paul Smelkinson (Phoenix), Robert C. Wetherhold (Seattle), and Charles L. Leonard (RCALJ, Region II). The ALJ Association was represented by its President, Paul Rosenthal.

Adjudicatory Policy

We are continuing to work with the other SSA components to develop uniformity in adjudicatory policies and standards for all elements of SSA. Our goal is to ensure that all levels of adjudication are following a single set of policies and guidelines, as determined by the Secretary. We had extensive discussions during the meeting concerning how these policies are developed and the manner in which OHA is participating in the process. Rhoda Greenberg of the Office of Disability Programs and Frank Dell'Acqua, Deputy Assistant General Counsel, Social Security Division, participated during this portion of the meeting. Much of the discussion centered on the proposal to give binding policy effect to disability adjudication guidelines in the POMS. As the result of a suggestion by Paul Rosenthal, we are considering as an alternative the publication of one or more Social Security Rulings to establish a single set of adjudicatory standards for all levels to follow.

In general, there are four major efforts underway in the area of developing more uniform adjudicative standards:

1) We are working with ODP to identify the specific portions of the POMS that are relevant to the adjudicative standards.

2) Program Policy Statements are being developed for a number of major topics, including residual functional capacity and transferability of skills.

3) We are attempting to identify additional case type disability rulings for publication as Social Security Rulings to provide additional precedential guidance to adjudicators.

4) We are promoting a more systematic review of court decisions to better identify candidate cases for appeal. As part of the discussion on this subject, Frank Dell'Acqua stressed the point that the federal courts do not run SSA's programs, and that ALJs are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court. Court decisions can result in the changing of policies, but it is not the role of ALJs to independently institute those changes.

Travel Allocation Cutback

Under the continuing resolution in effect at the time of the Policy Council meeting, OHA was operating under a 50 percent cut in travel funds in comparison to last year. Although we do not yet know how much travel money will be available for the remainder of the fiscal year, we definitely will have much less than we need and expected. We have no choice but to reexamine the way in which we have been doing business in regard to travel in view of this cutback.

We had considerable discussion about the issue of hearing assistant travel. The biggest reason for the change in policies on hearing assistant travel is that more than $1 Million would be spent on this type of travel this year under normal practices. We have therefore placed a general restriction on hearing assistant travel, with exceptions only being approved on an individual basis by the CALJ. We are, however, taking steps to continue to provide assistance to ALJs in conducting hearings while on travel. The availability of When Actually Employed (WAE) employees is being expanded throughout the country, and we are seeking temporary assistance from the district and branch offices located near hearing sites.

We are also re-examining the policies and procedures on claimant travel. During 1981, 51 percent of travel by ALJs occurred within 75 miles of the ALJ's office. Although it may be difficult to actually change the existing policies to extend the travel radius, there was general agreement from the Policy Council that OHA should more fully enforce the present policy. We will also encourage giving claimants the option to travel to the hearing office for their hearing, even if the distance is more than 75 miles.

Government Representative Experiment

The Government Representative experiment is being delayed at least until March 1982 so that a Federal Register Notice can be issued. Four offices will participate in the experiment. The goal of the experiment will be to evaluate the effect of a government representative on productivity and quality. Procedures for the role of government representatives are still being developed.

Blankenship

The government has filed a motion in the Blankenship case to obtain relief from the court-ordered time limits on the basis of drastically changed circumstances. We are arguing that the rapidly increasing workloads have changed the context of the original judgement, and have made the notion of time frame regulations and court-ordered time limits untenable. As a substitute, we are proposing to publish annually in the Federal Register a non-binding average processing time goal. If we are successful, we will not have to do special tracking of individual cases.

Attorney Fees

Proposed legislation is pending with OMB to eliminate SSA's involvement in attorney fee processing and approval. The Office of General Counsel is also analyzing the potential for regulatory change in this area. The Policy Council recognized that there are alternative remedies available for responding to problems that arise with certain attorneys aside from the fee authorization provisions.

Word Processing

The procurement of "state-of-the-art" word processing equipment for all hearing offices is underway. Installation will be on a phased basis beginning in Summer 1982. The equipment will include video display terminals and keyboards, and the printers will be capable of producing at twice the speed of our present equipment.

## Minimum Number of Cases Per Hearing Trip

A proposed policy was recently circulated to the field for comment regarding the establishment of the requirement for a minimum of 25 cases per hearing trip. Many of the responses on this proposal failed to recognize that it includes ample leeway for ALJICs to grant exceptions as circumstances warrant. This policy has been developed in response to the Inspector General's criticism of abuses within OHA and is in no way linked to any attempt to establish productivity quotas.

## Bellmon Review

The Bellmon "own-motion" review started on October 1, with 65 ALJs selected for review. Those ALJs who were selected have either the highest individual allowance rates or come from hearing offices with the highest overall allowance rates. The review covers 50 percent of the ALJs' allowance decisions on Title II and concurrent cases. For sample selection purposes, 100 percent of those workloads are being sent to Central Office. Sixteen hearings and appeals analysts are assigned to the review and are making recommendations for own motion to two Appeals Council members. There is an own motion recommendation rate of approximately 25 percent. Those cases on which the Appeals Council takes own motion are either reversed on the record or remanded to the ALJ. The Appeals Council is sending detailed descriptions of deficiencies to the ALJs for all own motion cases. Approximately seven and one-half percent of all ALJ allowances are now being reviewed. The number of cases will be doubled by April 1982 as additional analysts become available to participate in the review. Once the larger case review capability is achieved, a random sample of all ALJ allowance decisions will be added to the review.

A second aspect of the Bellmon amendment is the requirement for a report to the Congress concerning a study of the problems and differences in the adjudicative standards and approaches used at the various levels in the decisional process. The report, which is now being completed, concludes that there are major differences between OHA and the DDSs and between ALJs and the Appeals Council within OHA.

## Quality Control System

We are revamping OHA's Quality Control System to develop a mechanism to provide more direct and specific feedback to the field. I am concerned that the information generated by the present system is so general as to be of very limited utility. We are attempting to design a new procedure that will provide much better information to the field.

The Policy Council generally agreed that an improved quality control mechanism of this nature is needed to allow better identification of training needs and to accentuate areas where policy clarification is required.

## Reconfiguration

The original reconfiguration experiment involving six offices has led to expansion to approximately 30 offices in 1982. We will give priority in allocating resources, both in personnel and equipment, to these offices. Central Office and the Regional Offices will be working closely with all of the offices to assure smooth implementation. We are very mindful of the potential for short-term negative effects on productivity during implementation of the new processes, as pointed out by the Policy Council. However, we cannot ignore the significant potential long-term gains. In addition to the full reconfiguration of these 30 offices, we will also be encouraging other forms of innovative work processing.

## Staff Attorneys

There continues to be a high degree of interest in finding a method by which staff attorneys can qualify as ALJs. In view of our need to hire a large number of additional ALJs this year, we have to explore every opportunity to find high-quality candidates. Our staff attorneys could provide an excellent pool of such individuals.

The Policy Council agreed that staff attorneys should not be barred from qualifying for the ALJ register. The basic issue is to find a method to fulfill the requirement that candidates already working for the government must have one year of experience at the GS-14 level. It appears that the best method to address this problem would be to have OPM give approval for the experience of a GS-13 staff attorney as fulfilling the requirement for time in grade as a GS-14. OHA could then pursue the approval of supervisory GS-13 staff attorney positions in the Regional Offices and Hearing Offices. We are not presently pursuing any other alternatives, such as establishing GS-14 hearing examiners.

## Field Training Initiatives

We have established a Field Training Initiative Staff in Central Office under the direction of Irwin Friedenberg of the Washington, D.C., Hearing Office. Irv is working with Tom Capshaw to offer five continuing education seminars for ALJs beginning in April 1982. Each of these seminars will include a one and one-half day ALJ refresher training session in addition to the time utilized by the Continuing Judicial Education Committee. Additional training for all hearing office support staff is also being developed. OHA has allocated almost six times as much money for training in 1982 in comparison to last year.

Once again, the Policy Council meeting provided a frank and open exchange of ideas on the important issues facing OHA. The advice and opinions expressed by all of the participants were extremely valuable and resulted in several significant policy decisions.

Louis B. Hays

Louis B. Hays

cc: RCALJs
OHA Executive Staff

1625

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

June 3, 1982

Hon. Carl Levin
Senator
Subcommittee on Oversight of
Governmental Affairs
140 Russell Senate Office Building
Washington, D.C. 20510

Dear ~~Senator Levin:~~ Carl

We are very concerned about the tragic impact of the Social Security Disability cessations and terminations on disabled New Yorkers, as well as the fiscal impact on local governments.

Therefore, we are submitting written testimony describing in detail our concerns, for inclusion in the record of your May 25 hearing.

Thank you for your important initiative in this area.

Sincerely,

Carol

City Council President
Carol Bellamy

Edward I. Koch
MAYOR

EIK:peh

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

TESTIMONY BY

EDWARD I. KOCH
MAYOR, NEW YORK CITY

CAROL BELLAMY
PRESIDENT, NEW YORK CITY COUNCIL

JAMES A. KRAUSKOPF
ADMINISTRATOR, NEW YORK CITY HUMAN RESOURCES ADMINISTRATION

BEFORE THE U.S. SENATE
COMMITTEE ON GOVERNMENTAL AFFAIRS
SUBCOMMITEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

OVERSIGHT HEARINGS ON SOCIAL SECURITY DISABILITY TERMINATIONS

SENATOR WILLIAM COHEN, CHAIRMAN

MAY 25, 1982

We are Edward I. Koch, Mayor of New York, Carol Bellamy, President of the New York City Council, and James A. Krauskopf, Administrator of the Human Resources Administration. We welcome this opportunity to testify about the impact of recent federal initiatives which substantially reduce the number of Social Security Disability (SSD) and Supplement Security Income (SSI) recipients. Specifically, we will discuss the effect the new accelerated case review process has had on the approximately 240,000 disabled beneficiaries in New York City and the related fiscal impact of these initiatives on our city. In addition, we will discuss difficulties we believe would be caused by H.R. 6181, which proposes to change the review and appeals procedures for disability benefit applications and eligibility reviews.

Beginning in 1980, Congress required periodic case reviews of all mentally disabled Social Security beneficiaries. The legislative purpose was laudatory: to ensure that all federal disability beneficiaries are, in fact, unemployable due to their mental or physical impairment and deserve to receive benefits. Unfortunately, this laudatory purpose is being undermined by improper implementation.

The harsh reality is that tens of thousands of "truly" disabled have lost their federal benefits. Their recurring and debilitating illnesses were apparently routinely ignored.

If properly structured and funded, the accelerated eligibility review process could work to reduce waste without disrupting the lives of disabled people. We are concerned, however, that the disability eligibility standards now being applied and the procedures followed in making the determinations are leading to incorrect terminations which often result in personal tragedy for the most vulnerable members of our society.

We believe the best way for Congress to determine if the review process is being conducted properly is to examine the case histories of persons who have lost their benefits. Ostensibly, these persons are no longer disabled and could resume work. But we will share with you the stories of three people who have contacted Council President Carol Bellamy's Ombudsman's Office concerning their disability terminations because we believe these cases are illustrative of thousands of improper terminations being made in New York City and across the country.

Frank Santini* is a 51 year old former longshoreman who suffered a severe heart attack in 1977. He began receiving Social Security Disability benefits in June 1978 for himself, his wife and his two children. In the fall of 1981, Mr. Santini received notice that his case was being reviewed. He was given an appointment for an examination by a Social Security consulting physician. He was asked to undergo a treadmill stress test. During the stress test, Mr. Santini complained of pains in his legs and in his chest. The doctor told him that it was all right and that he should continue the test or he would be required to come back and repeat it. Mr. Santini continued.

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*Pseudonyms are used to protect individuals' privacy.

Upon leaving the examination, Mr. Santini collapsed. He refused to return to the examination building because of the treatment he had received there, and was taken home. When his condition did not improve after bed rest, he was hospitalized and a cardiac catherization revealed two blocked arteries and problems with a third. The doctors indicated that some of the damage was caused by the treadmill test, and commented that it was poor medical procedure to have allowed him to continue the test despite his pain.

Although the Office of Disability Determinations was notified of Mr. Santini's medical condition, he was terminated from the disability rolls in December. He has filed for reconsideration and is awaiting a decision. Meanwhile, he has had to undergo cardiac bypass surgery.

Agnes McElroy is 58 years old and was determined to be disabled in 1974. She has a second grade education because she was forced to leave school at the age of seven due to recurrent bouts of rheumatic fever. She spent the next eight years confined to bed. She developed congestive heart failure as a result of the rheumatic fever.

Through her life, Mrs. McElroy worked only part-time jobs as a telephone operator, resting when her health required it. She presently becomes short of breath when walking less than a block.

After undergoing a three minute medical examination by a physician under contract to the Office of Disability Determinations, Mrs. McElroy's benefits were terminated as of January 1982. Her termination notice read: "You are initially found to be disabled because of arthritis, and a heart problem. The medical evidence shows that ... your condition has improved." Her condition has not improved, nor has she ever had arthritis. Her case is also on appeal.

John Gables is 46 years old and has a ten year history of manic-depressive psychosis. He has experienced twelve manic episodes requiring hospitalization, most recently in August, 1981. He is able to live alone with the support of the Bridge Social Rehabilitation Program, which he has attended daily for the past two years. He also regularly goes to St. Luke's Psychiatric Outpatient Clinic and takes lithium to control his symptoms.

His last full-time job was in 1973. In 1977, Mr. Gables enrolled in an Office of Vocation Rehabilitation training program but was forced to drop out after a month because it was too stressful. In 1980, he tried to work as a census taker, but again work proved too stressful, and he was rehospitalized. In September 1981, he was asked to submit evidence to support his claim of psychiatric disability. Despite the fact that all the professional staff at the Bridge sent letters stating that Mr. Gables was unemployable, his claim was initially denied.

The director of the Day Program at the Bridge commented about the termination decision: "His case is really sad because he would really like to work but his illness prevents him ... he manifests severe depression which makes it difficult for him to function. He also has periods when he is really manic. He has difficulty sleeping then and often becomes delusional." Mr. Gables had to be rehospitalized one week after his hearing before the Administrative Law Judge.

For many recipients, the termination of benefits represents the loss of their sole source of income. Their only recourse is to apply for other forms of public assistance. Thus, what began as a laudable program to ensure that federal dollars are being spent properly, is becoming instead another means of shifting responsibility from the federal government to State and local jurisdictions without providing adequate resources.

Large scale disability terminations will not only affect individual recipients; but will also create a severe strain on already overburdened state and local governments. The fiscal impact of the terminations, of course, will depend on the number of cases reviewed, the number of terminations, and the number of cases reinstated on appeal. The State plan is to increase its rate of review to 38,000 cases in FY 1982 and 88,000 cases by FY 1984.

We estimate that 17,000 disabled men and women in New York State will lose their federal disability benefits in FY 1982. If only 25 percent of those persons apply for and receive Home Relief — New York State's welfare program for single adults — the total statewide cost will be $10. 6 million, with the State picking up $5.3 million, New York City $2.2 million and other New York localities $3.1 million. When review of the SSI population begins, the financial impact will be even greater. Some of the other terminated recipients will not know where to turn, and may even be forced to seek refuge in a City shelter.

We can also predict that local Medicaid costs will rise as Social Security recipents lose their Medicare coverage.

It should also be noted that only half the states administer and fund welfare programs for single adults. In the remaining states, recipients who lose disability benefits are left totally without support.

An additional problem exists because many disabled persons lose benefits because of their inability to negotiate the complex review and appeals procedures. This is particularly true for mentally ill beneficiaries who represent one-third of the federal disability recipients in New York City. This problem is documented in a January 1982 report of City Council President Carol Bellamy, "Passing the Buck: Federal Efforts to Abandon the Mentally Disabled," which we are appending to the testimony.

Federal disability benefits can be, and often are, terminated even before a formal case review takes place. Under federal law, the burden to submit required evidence rests solely on the beneficiary. Failure to supply this information is grounds for termination. Placing this responsibility on mentally ill men and women is simply unfair. A three page questionnaire, which must be completed and returned, is attached to the notice of review. Medical evidence is required to document the beneficiary's claim of mental disability. And even if the questionnaire is returned and medical evidence provided, the Department of Social Services may require the beneficiary to show up and submit to a medical and/or psychiatric examination.

This process is difficult enough to negotiate when the mentally ill have social workers advocating on their behalf. For people without any direct assistance from a mental health program, it is most often impossible.

Even if disability recipients manage to comply with the complex review and appeals procedures, many seriously ill individuals are still denied benefits due to the federal government's continued narrowing of eligibility criteria. Changes in the eligibility criteria have frequently been initiated by internal memoranda and directives, and oral instructions from the Social Security Administration to the reviewing agencies and have not been subject to public scrutiny.

As our examples demonstrated, the use of the new criteria has resulted in the termination of benefits to persons who are unable to work, forcing them to compete with the able bodied for jobs at a time of record breaking unemployment. For example, the current disability standards would even prevent an individual who meets most states' criteria for commitment to a psychiatric hospital, to be found capable of unskilled work.

Similar problems exist with the standards for heart disease, respiratory illness, and other physical disabilities. The fact is that most employers would not consider hiring the persons' judged employable by disability analysts following federal guidelines. And many of those terminated are simply not able to work, even if a job was available.

Now, we would like to comment on HR 6181, the Disability Amendments of 1982, which is awaiting consideration by the House. We oppose two provisions of this bill — sections 5 and 7 -- which we believe will deprive the disabled of an opportunity for a thorough case review before an Administrative Law Judge (ALJ). The result: even a greater number of deserving recipients will be denied benefits.

Section 5 would undermine the role of the ALJ and the recipient's right to a fair and impartial hearing. The provision would seal the case record at the reconsideration level. Also, reconsideration is to be conducted by the state agency which determines eligibility and administers the benefits. Thus, the review is not performed by an independent party. In addition, it must be remembered that very few people are represented until the ALJ stage, where they are assisted in obtaining evidence. State disability agencies are unlikely to have the staff or the resources necessary to assist recipients in obtaining all material necessary to ensure a fair review, which means that in most cases disabled recipients must locate all of the required medical and vocational evidence. In fact, despite a 53 percent increase in its workload in 1982, New York State's Office of Disability Determinations' budget has only been increased by 2.5 percent when adjusted for inflation.

Disabled claimants deserve full due process to argue their case, particularly mentally disabled individuals who must pass tests which are inherently subjective. These persons are entitled to an impartial face-to-face hearing before an Administrative Law Judge.

Section 7 presents even more serious problems. While we agree with the goal of section 7 — to create uniform standards at all levels of review — we object strenuously to the provision's open-ended language which would allow the Social Security Administration to do whatever it wishes relative to the establishment of uniform standards.

We oppose the use at the ALJ hearing level of any standards that are not issued for public comment. It is critical that the public be fully aware of the disability determination process and the standards used. SSA is already utilizing informal instructions such as the Social Security Rulings and the Program Operations Manual Systems to reduce the number of claims allowed. By requiring the publication of all eligibility criteria, uniform standards will be assured and the rights of the disabled will be protected.

We urge that the committee take the following actions:

- Appoint an independent board of medical experts for the purpose of reviewing and revising the current medical listings.

- Place primary emphasis on reports by treating doctors as proof of disability, except where there is evidence that the report may be inaccurate.

- Amend the 1980 laws requiring eligibility reviews for all disabled to exempt those recipients who are 59 and over, or who have been out of the work force due to a disability for more than 15 years.

- Allocate funds for vocational rehabilitation and job placement purposes for those disability recipients who are judged ineligible, and extend benefits during the training period.

- Require the SSA to provide funds to state agencies to enable them to provide personal assistance to the mentally disabled in complying with the complex review procedures, as well as legal representation for all appeals.

Thank you for the opportunity to share our concerns regarding changes in Social Security Disability and Supplemental Security Income Programs. We believe that the accelerated review process can be implemented successfully without jeopardizing the rights of the disabled who legitimately depend on disability benefits for their life support. Elimination of the current abuses, however, requires action in the coming months. New York City asks for your leadership on this issue, and stands ready to assist in any way possible.

A REPORT

OFFICE OF THE
CITY COUNCIL
PRESIDENT

# PASSING THE BUCK:
## FEDERAL EFFORTS TO ABANDON THE MENTALLY DISABLED

JANUARY 1982

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Appendix

This report was prepared by Cindy Freidmutter and Audrey Hutchinson with the assistance of Barry Ensminger.

## I. Introduction

Over 160,000 people receive Social Security Disability (SSD) and Supplemental Security Income (SSI) benefits each month in New York State as a result of being mentally disabled and unable to work. Many of these people are state psychiatric hospital dischargees, living in single room occupancy hotels, adult homes and community residences. They are dependent on federal disability benefits to buy food and pay the rent.

Thousands of these chronically ill, mentally disturbed men and women will lose these benefits due to a federal initiative to re-examine the eligibility of all disabled Social Security beneficiaries. While the publicly-stated intent of this action is to eliminate improper payments to employable people, the harsh reality is that many "truly" mentally disabled are being terminated as well. The fact that they still suffer from recurring and debilitating mental illness is apparently being routinely ignored.

An estimated 5,500 mentally disabled beneficiaries in New York State (including 2,300 in New York City) will lose benefits in federal fiscal year 1982 alone. (See Appendix I-A) This federal initiative is yet another way in which the Reagan Administration is removing the federal safety net for helpless people dependent on government benefits for survival.

The outcome of this process is all too predictable. After losing federal disability benefits, some people will apply for the public assistance program of last resort, Home Relief, further increasing state and local welfare costs.

The less fortunate will end up destitute on the streets, causing yet another surge in the number of homeless people in New York City.

## II. Federal Social Security Programs for the Mental Disabled

To qualify for SSD and SSI disability benefits, applicants must establish their "inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[1] Three major factors are taken into consideration: current work activity, the severity and duration of the impairment(s), and current capacity for employment.[2]

For many mentally ill New Yorkers, federal disability benefits -- which average $413 a month -- are the mainstay in their lives.[3] SSD and SSI are the only sources of income for thousands of chronic, mentally disabled patients discharged from State psychiatric institutions during the past two decades of deinstitutionalization. Of the 463,000 State residents receiving SSD and SSI benefits, 160,700 are mentally disabled. More than half of the mentally disabled -- 83,900 -- live in New York City.[3a]

Table 1

Number of Mentally Disabled Federal Disability Recipients in New York State and City (rounded to nearest hundred)

| | New York State | New York City | Percentage of State Total |
|---|---|---|---|
| -SSD | 78,300 | 32,800 | 42% |
| SSI | 82,400 | 51,100 | 62% |
| Total | 160,700 | 83,900 | 52% |

Source: New York State Department of Social Services

The SSD and SSI Programs are both administered by the Social Security Administration (SSA).* Rules and regulations governing eligibility, procedures for evaluating applicants, and reviewing the status of current beneficiaries are promulgated by the SSA. The federal government contracts with the states, however, to actually perform the initial eligibility determinations and status reviews. In New York State, the Department of Social Services (DSS) performs these functions.

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*SSD benefits are paid to disabled individuals who have contributed to the Social Security System for the required number of quarters. SSI benefits, on the other hand, are not based on contributions to the Social Security fund but are paid from general tax revenues to the financially destitute.

## III. Federal Disability Benefits Are Being Terminated for Thousands of Mentally Ill Beneficiaries in New York

The Social Security Act was amended by Congress in 1980 to require periodic reviews of all SSD beneficiaries at least once every three years.[4] Previously, eligibility reviews were conducted only when a mental disability was expected to improve, not for chronic psychiatric conditions. As a result of the 1980 amendment, the number of SSD reviews is expected to rise dramatically from 160,000 nationwide in 1981 to 360,000 in 1982.[5]

SSI recipients are now being reviewed in cases where mental illness is considered temporary. However, the Social Security Administration has the authority to institute periodic reviews for all mentally disabled SSI recipients as well, and is expected to do so beginning late 1983 or 1984.[6]

The accelerated review process is well underway in New York State. In the last six months of 1981, reviews of SSD cases increased by 39 percent over the same period in 1980.[7] And the Social Security Administration has an ambitious schedule for the future: reviews are expected to soar by more than 500 percent from 1980 to 1984 -- from 16,000 to 88,000 annually.[8]

At the same time, denial rates are going up as more and more disabled beneficiaries are losing benefits after their case review. In 1981, the proportion of SSD case closings after review rose by nineteen percent over 1980.[9] Similarly, the rate of SSI case closings increased by 22 percent from 1980 to 1981.[10]

What will these people do when their basic life support income is terminated? Many will turn to the public assistance program of last resort -- Home Relief; others will join the tens of thousands of homeless men and women wandering the streets or sleeping in City shelters each night. In 1982, an estimated $28 million in federal SSD benefits will be lost statewide ($12 million in New York City alone). (See Appendix I-B). If only half of these troubled people go onto Home Relief, it will cost New York State $3.5 million annually, New York City $1.5 million and other localities $2 million, just to support the mentally ill abandoned by the federal government. (See Appendix I-C). Moreover, additional shelters will have to be opened for the homeless.

Mr. Robert Trobe, Deputy Administrator for Family and Adult Services in the Human Resources Administration, aptly summarized the impending problems for New York City:

> "This federal initiative can only mean added costs to New York City. When federal disability benefits are terminated, the mentally ill will inevitably turn to home relief or the City's shelters. This additional burden could not be coming at a worse time."[11]

Table 2

SSD Reviews in New York State, 1980-1981

| | Period | | Percent |
|---|---|---|---|
| | 5/2/80-12/26/80 | 5/1/81-12/4/81 | Increase |
| Number of Cases Reviewed | 7,597 | 12,440 | 39% |
| Number of Denials | 2,808 | 5,437 | 49% |
| Percentage of Denials | 37% | 44% | 19% |

Source: New York Regional Office of the Social Security Administration

## Table 3

## Five Year Schedule for SSD reviews in New York State

| Year | Number of Reviews |
|---|---|
| FY 1980 | 16,000 |
| FY 1981 | 20,000 |
| FY 1982 | 38,000 |
| FY 1983 | 63,000 |
| FY 1984 | 88,000 |

Source: New York State Department of Social Services

## Table 4

## SSI Reviews In New York State, 1980-1981

| | Period | | |
|---|---|---|---|
| | 5/2/80-12/26/80 | 5/1/81-12/4/81 | Percent Increase |
| Number of Cases Reviewed | 6,049 | 5,545 | (-11%) |
| Number of Denials | 2,690 | 3,017 | 12% |
| Percentage of Denials | 44% | 54% | 22.7% |

Source: New York Regional Office of the Social Security Administration

## IV. In Many Cases, Reviewers are Abusing Their Authority and Terminating the "Truly" Mentally Disabled

At a time when the Social Security system is experiencing major financial difficulties and public funds for social programs are in short supply, no one can argue with the need to maintain strict procedures to insure that disability benefits are not provided to mentally competent people who are able to work. However, it appears that many clearly eligible, mentally disabled beneficiaries are being terminated after case reviews.

In assessing whether someone has the mental capacity to work, reviewers are legally required to "consider factors such as [the] ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting."[12] After a series of interviews with mental health professionals and legal services lawyers, it appears these factors are routinely being ignored.* For the mentally ill, the consequences can be devastating.

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*Mental health professionals in seven agencies serving the chronically mentally ill were surveyed -- Transitional Services, The Bridge, the St. Francis Residence, the Washington Heights-Inwood Community Mental Health Center, the Soundview Throgs Neck Community Mental Health Center, South Beach Psychiatric Center and Kings County Hospital. Attorneys representing the mentally disabled from Lawyers for the Public Interest and Legal Services for the Elderly Poor were interviewed as well. Together, these professionals provided information on dozens of disability recipients whose eligibility status was recently reviewed. In the opinion of the health professionals surveyed for the report, none of the individuals terminated from the federal disability rolls were "employable" in any realistic sense. (See Appendix II for the names and titles of mental health professionals and legal services lawyers interviewed for this report.)

## Harry Baird* of the St. Francis Residence[13]

Forty year old Harry Baird is both mentally and physically disabled. Prior to 1973, he had been hospitalized at least once a year for two to three week periods. He has been known to the St. Francis priests since 1973, when he was released from the Manhattan State Psychiatric Hospital. Mr. Baird is diagnosed as suffering from chronic schizophrenia.

Since he became affiliated with the St. Francis program, his mental condition has somewhat stabilized. He has been hospitalized only three times since 1973, the most recent in November, 1980. With the aid of the St. Francis escort service, he regularly attends a state psychiatric clinic, and he receives medication daily at the residence.

In the summer of 1981, Mr. Baird was hospitalized at Bellevue with chest pains and high blood pressure. Doctors found that his heart was enlarged to the size of a football; his prognosis was described as very poor.

In August, 1981, Mr. Baird received notification that his SSD eligibility was being reevaluated, and that he had to appear on two separate occasions for physical and psychiatric examinations. Despite his appearances, Mr. Baird received in September a letter of termination, which he appealed with the help of the St. Francis staff.

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*All names of disability recipients used in this report are pseudonyms.

Questioning the reasonableness of the decision that Mr. Baird was "employable", St. Francis social worker John Gaines described his client's limited capacity to perform even simple tasks:

> "When you speak to this man, he simply doesn't understand what you are talking about. He often doesn't respond. We have to watch him take his medication to make sure he doesn't take the wrong thing at the wrong time. He could not even get to an appointment at the Social Security office on his own. He must always have an escort."[14]

Dr. Charles Rosenbloom, his treating psychiatrist, also questioned the decision.

> "[Mr. Baird] suffers from chronic auditory and visual hallucinations, including command hallucinations of a suicidal nature; the patient has acted on these command hallucinations on more than one occasion in the past. These symptoms do not disappear with the psychotropic drugs which he receives at the clinic.
>
> "[He] has the fragile ego structure of a chronic schizophrenic. He is unable to cope with the stress of everyday life without the constant support of the on-site staff at his residence and the interventions of this clinic. He is a fearful, isolated individual who is totally dependent upon the social structure provided by the residence. He has been referred to Day Programs on several occasions in the past, but these experiences have proved to be so threatening that his symptoms increased to an alarming degree (particularly in view of his suicidal attempts,) and the programs were discontinued.
>
> "Since [Mr. Baird] is unable to relate in the relatively safe environment provided by a therapeutic day program it is impossible to consider him as a candidate for employment. His prognosis remains extremely guarded and his ability to assume competitive employment, even at a most basic level, is non-existent. There is no time in the foreseeable future that this prognosis will improve based on our observations of his capacity to cope since he began treatment with us in 1973.
>
> "We hope that you understand the seriousness and indeed life threatening nature of [Mr. Baird's] disability and will reinstate him on the disability rolls."[15]

In November, Mr. Baird received a final notice that benefits were being terminated. The letter stated that, while he might not be able to resume his previous occupation (he had been a cart-pusher in the garment district), he could perform some kind of work.

With the assistance of the St. Francis staff, Mr. Baird filed a final appeal and is now waiting for a hearing to be scheduled.

The church has deferred Mr. Baird's rent and is loaning him money for food and other expenses. Priests at St. Francis state that if he were on his own he would never be able to pursue the appeal. He cannot read and hands his correspondence unopened to the St. Francis workers. They believe he is not really aware of his situation.

Alan Palmer of South Beach State Psychiatric Hospital[16]

After his SSI benefits were terminated, Alan Palmer threatened to assassinate President Reagan and was admitted to South Beach State Psychiatric Hospital as a result. Thus, just days after being notified by the Department of Social Services that he was "employable", psychiatrists were hospitalizing Mr. Palmer as delusional and a danger to others.

Linda Breslin, Deputy Director of South Beach, emphasized that he "could maintain himself out of the hospital but could never work. The stress of having his livelihood cut off led to the last hospitalization and rather drastic threat."[17]

Jane Rollen of Washington Heights CMHC[18]

Jane Rollen is a 46 year old woman, living at the Washington Heights-Inwood residence since January 1981. Previously, she was homeless and slept on the streets of Manhattan.

In 1967, Ms. Rollen began receiving SSD and SSI disability benefits (after she became delusional and was diagnosed as suffering from chronic schizophrenia). Since then, she has undergone several psychiatric hospitalizations, the most recent in the spring of 1980. Ms. Rollen also suffers from severe back pain as a result of a previous injury. She attributes the back pain to possession by demons.

In November 1981, Ms. Rollen was notified that her disability benefits would be terminated because she was determined to be "employable". With the help of her counselors, she is now appealing that decision.

John Gables of The Bridge[19]

Mr. Gables is 46 years old and has a ten year history of manic-depressive psychosis. He has experienced twelve manic episodes requiring hospitalization, the most recent in August, 1981. Divorced when he became ill, Mr. Gables has lost all contact with his former wife and two children. With the support of the Bridge Social Rehabilitation Program, which he has attended daily for the past two years, he is able to live on his own. He is also seen regularly at St. Luke's Psychiatric Outpatient Clinic and takes lithium to control his symptoms.

His last full-time job was in 1973. In 1977, Mr. Gables enrolled in an Office of Vocation Rehabilitation training program but was forced to drop out after a month because it was too stressful. In 1980 he tried to work as a census taker, but again work proved too stressful and he was rehospitalized.

In September, 1981, Mr. Gables was asked to submit evidence to support his claim of psychiatric disability. Despite the fact that all professional staff members at the Bridge sent letters stating that Mr. Gables was unemployable, his claim was turned down.

Jane Michele, Director of the Bridge's Day Program commented on the DSS decision. "Mr. Gables is motivated to work as indicated by his history and he has attempted to return to work, but he manifests severe depression which makes it very difficult for him to function. He also has periods when he is really manic. He has difficulty sleeping then and often becomes delusional. He is also very hyperactive. His case is really sad because he would really like to work, but his illness prevents him."

Mr. Gables had his hearing on January 19, 1982. Ms. Michele says that the stress was too much for him and he will probably need to be rehospitalized.

Sadly, Harry Baird, Alan Palmer, Jane Rollen and John Gables do not seem to be isolated and atypical examples of mentally disabled people now being terminated from the Social Security Disability rolls.

Many psychiatrists and social workers interviewed for this report expressed anger at the termination of benefits for vulnerable men and women under their care. Dr. Itamar Salaman, Director of the Soundview-Throgs Neck Community Mental Health Center, echoed the feelings of many of his colleagues in his criticism:

> "The disallowance of disability coverage appears to be an arbitrary, unfeeling and unthinking procedure causing great distress to large numbers of very chronically and seriously ill psychiatric patients and their families. It is only with great effort and much support that these people are able to remain outside of hospitals. The ultimate outcome of this inhumane policy will be to add to the numbers of homeless and to increase the psychiatric readmission rate to hospitals, thus shifting the financial burden for caring for these helpless people to the cities and states. The cost of hospitalization is far greater than keeping them in community-based programs."[20]

Ms. Margaret Murphy, Human Resources Coordinator for Transitional Services, a mental health program for the chronically ill located in Queens, said that the number of terminations of seriously ill program participants had increased dramatically. Between August and December, 1981, she accompanied 18 clients to disability hearings after their benefits were terminated, compared to one hearing every three months previously. She reported that all 18 clients were chronically disabled with long-term, serious and extensive psychiatric problems:

> "I have been with clients on occasions when they were experiencing psychotic episodes at the hearings, and the hearing officer still upheld the denial of benefits.
>
> "The slightest progress evidenced by our clients was used as the justification to terminate benefits at a time when these men and women were clearly not ready for completely independent living. Loss of income at that stage wiped out years of progress by triggering a relapse or causing the client to leave the program prematurely."[21]

Dr. Ginny Gerbino, attending psychiatrist at Kings County Hospital, has treated many patients after SSD benefits were terminated:

> "Despite the fact that mentally disabled patients are out of the hospital, they are often not employable. These people, who are most in need of what public assistance benefits have to offer, are rendered helpless when benefits are cut off precipitously. It is tantamount to punishing these patients for the progress they have made in staying out of the hospital.
>
> "One of the great misunderstandings of this particular problem is that progress made in remaining out of the institution and adjusting to living in the community is the same as employability. It is not."[22]

When questioned about the impact of the eligibility reviews on his patients, Dr. Roger Brunswick, Medical Director of the Bridge, said:

> "Chronic psychiatry patients live in a very precarious state of mental health. Predictability in their lives leads to the least amount of stress and results in a dramatic decrease in psychotic episodes and hospitalizations. Most of them have tried to work in the past and have not been able to tolerate even the stress of the easiest jobs.
>
> "Cutting off the disability benefits of chronic mental patients is to cut off one of the only constant things in their lives and, as it would be for anyone, it is a major stress. We have seen at the Bridge, a number of psychotic decompensations and hospitalizations as a result of the discontinuation of benefits. In people who have already shown their difficulty in competing in the world of work, cutting off their only financial support is a catastrophe."[23]

The federal disability recipients discussed here are all involved in mental health programs which have provided support and advocacy for their patients undergoing review. They have also given financial support when benefits were terminated. Yet, due to New York City's inadequate community mental health system, only a fraction of the chronically mentally disturbed population have access to such services.*

Mentally disabled SSD and SSI beneficiaries not receiving services from a mental health or social service agency are even more likely to lose benefits; not because they are more "employable", but because they are unable to effectively cope with the bureaucratic process.

Mr. Robert Hayes, the attorney for homeless plaintiffs in Callahan v. Carey,[24] is alarmed by the threat to the economic stability of SRO and adult home residents:

> "Many of these poor disabled people simply cannot negotiate the bureaucratic maze by themselves. With recent cutbacks in legal services programs, they'll go unrepresented. When their checks stop, they lose their place to live. That is how people become homeless."[25]

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*In New York City, only six percent of the chronically mentally ill are receiving case management social services, and 22 percent are receiving needed clinical treatment. (Source: New York State Office of Mental Health 1981 Five Year Plan.)

## V. Complying With Complex Review Procedures Is Often Difficult For Confused Mentally Ill Beneficiaries.*

Federal disability benefits can, and often are, terminated even before a formal case review on the merits takes place. Under federal law, the responsibility to submit all evidence required for review rests with the beneficiary. Failure to supply this information is ground for termination.

Placing this responsibility on mentally ill men and women is obviously problematic. A three page questionnaire is attached to the notice of review which must be completed and returned. (See Appendix IV). Medical evidence is required to document the beneficiary's claim of mental disability. Even if the questionnaire is returned and medical evidence provided, the Department of Social Services may require the beneficiary to show up and submit to a medical and/or psychiatric examination.[26]

This process is difficult enough to negotiate when the mentally ill have social workers advocating on their behalf. For sick people without any direct contact with a mental health program, it can be impossible. The Department of Social Services purports to deal with this problem by referring all cases (where the mentally disabled do not respond to two notices) to SSA district offices for a home visit.

In fact, it does not appear that Social Security offices are personally assisting all mentally disabled beneficiaries who need help, although the dimensions of the problem are unclear. Ms. May Blatt, Director of the New York City Regional Office of the DSS Office of Disability Determinations, could not provide any figures on the numbers of cases already referred for home visits. In another attempt to understand the actual availability of home visits, we directly contacted intake workers at the Social Security Administration and Department of Social Services.

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*Appendix III describes the various stages of the review process.

Three workers at the central information number for Social Security were telephoned; each stated that mentally disabled beneficiaries receiving checks directly were considered to be "competent" and were automatically terminated if they didn't reply to the review notices. Local Social Security offices in Brooklyn, Queens and Manhattan were also contacted. Intake workers in these offices stated that the DSS Office of Disability Determinations did forward requests for home visits for some mentally disabled beneficiaries under review, but could not say whether this occurred in all cases. When the Division of Disability Determination was telephoned again, we were told that home visits could be requested but that the decision was discretionary and not done in every case.

Even with proper assistance, the mentally ill often have trouble representing themselves during the review process. A social worker at Transitional Services, Joseph Berkman, says that patients generally approach the hearings with "intense feelings of anxiety. In some cases, they become emotionally paralyzed when confronted with it."[27]

Problems were also found with the psychiatric examinations conducted by DSS for beneficiaries that did manage to complete and return the initial questionnaire. DSS requires that a thorough mental status examination and complete medical history be done.[28] The reality, however, can be quite different.

One chronic patient at the Soundview-Throgs Neck Community Mental Health Center was recently taken off thorazine because of her adverse reaction to the medication and given valium to minimize her disruptive behavior. According to the patient, who is considered reliable by her social worker, the examination consisted of the following:

M.D.: "Hello."

Patient: "Hello."

M.D.: "What kind of medication are you on?"

Patient: "I'm on Valium."

M.D.: "Oh...you are on Valium. You are not sick!"[29]

The father of a South Beach Psychiatric Center Outpatient timed the length of his son's examination -- it lasted four minutes. Ms. May Blatt admitted that it is impossible to do the kind of work-up required by the agency in that limited time period.

Formal appeals are available after an unfavorable review decision, but effective representation is even more important at this stage. Unfortunately, many mentally disabled beneficiaries lack this assistance as well. According to Linda Breslin, the Deputy Director at South Beach State Psychiatric Hospital:

> "It appears to us that many more patients are categorically being denied SSD and SSI benefits and are not being recertified. We are often able, however, to reverse the final denial of benefits for our patients during the appeals stage. It is State Office of Mental Health policy to appeal all of these cases.
>
> "This requires an enormous amount of time and work. Our clients do not have the resources to hire or locate attorneys, nor can they understand the complications and intricacies of the appeals process.
>
> "It is highly unlikely that confused and disorganized individuals who do not have the support of a skilled professional working on their behalf could negotiate the appeals system."[30]

The large numbers of the mentally disabled forced to confront this process on their own may, because of their inability to comply with the review requirements, lose their benefits without ever having a fair review of the merits of their claim. Without personal assistance by DSS and SSA at every stage of the process, many "truly" disabled men and women will lose their only source of support and be forced into the shelters and onto the streets.

DSS officials concede that they have not been given the financial resources to provide effective personal assistance to the mentally disabled who need it.[31] The SSA has raised the number of eligibility reviews for New York State, but it has not increased DSS's budget accordingly, making it difficult for DSS to adequately review each case. From 1981 to 1982, the number of scheduled reviews is projected to increase by 53 percent while DSS's budget has been raised by only about 2.5 percent in real dollars.[32]

With all these apparent difficulties, the burden is on the Social Security Administration and Department of Social Services to demonstrate that the review process is procedurally fair to the mentally disabled. Requests for more detailed information have been sent to SSA and DSS to enable more comprehensive analysis by the City Council President's Office. (See Appendix V).

## VI. Conclusion and Recommendations

Beginning in 1980, Congress required periodic case reviews of all mentally disabled social security beneficaries. The legislative purpose was laudatory: to assure that all federal disability beneficiaries are, in fact, unemployable due to their mental or physical impairment. Unfortunately, this laudatory purpose is being undermined by improper implementation. Placing the burden of proof on mentally disabled beneficiaries is a serious injustice to the many beneficiaries too ill to represent themselves. Without adequate assistance, confused and disturbed people are being terminated for failure to cooperate before a review on the merits even takes place. In other instances, beneficiaries with severe impairments are deemed "employable" despite strong psychiatric evidence to the contrary.

The State Department of Social Services has already agreed to cooperate with the Council President's ongoing investigation of this problem. Further analysis will be developed in the coming months as additional information is provided. In the meantime, it is clear that a number of steps must be taken immediately:

1. Social Security Disability benefits for mentally disabled beneficiaries should not be terminated prior to a case review on the merits. Failure to respond to written notices, complete the questionnaire, provide medical documentation, or show up for a psychiatric consultation cannot be

the basis for automatic termination of benefits to chronically mentally ill people.

2. Mentally disabled beneficiaries must be provided with personal assistance (and home visits if necessary) throughout the review process. Legal representation should be provided for appeals after the initial case review. The Department of Social Services should consider contracting with the private bar or legal services attorneys with experience in social security disability hearings to provide the necessary legal assistance to beneficiaries.

3. Psychiatric social workers and psychiatrists working in community mental health programs should be given training in what type of information is required by the Social Security Administration to verify mental disability.

4. The Department of Social Services should begin a study of the impact of terminating federal disability benefits on rehospitalization rates, the mental health of beneficiaries, home relief rolls, and City shelters for the homeless.

5. The Congress should schedule hearings on the implementation of the 1980 amendment, its fiscal impact on state and local government, and the appropriateness of placing the burden of proving continued disability on mentally impaired beneficiaries.

## FOOTNOTES

1) Social Security Administration Rules and Regulations, 20 CFR Subpart P, §404.1505

2) Ibid., Subpart P

3) Social Security Disability Bulletin, (Social Security Administration, December 1981)

3a) Telephone Interview with Lloyd Moses, Associate Commissioner, NYS Office of Disability Determination, December 31, 1981

4) PL 96-265 (June 9, 1980)

5) Wall Street Journal (December 1981)

6) Telephone Interview with Lloyd Moses, Associate Commissioner, NYS Office of Disability Determination

7) Telephone Interview with Helene Ebenstein, Coordinator, New York Regional Office of the Social Security Administration, on December 23, 29, 30, 1981. Also See Table 2.

8) Telephone Interview with Lloyd Moses. See Footnote 6.

9) Telephone Interview with Helene Ebenstein. See Table 2.

10) Ibid., Also see Table 4.

11) Telephone Interview with Robert Trobe, Deputy Administrator for Family and Adult Services of the Human Resources Administration, on January 19, 1982.

12) Social Security Administration Rules and Regulations, 20 CFR, Subpart P, §416.945(c)

13) Telephone Interview with Al Pettis, Program Director, St. Francis Residence, on December 29, 1981, January 5 and 6, 1982.

14) Telephone Interview with John Gaines, Social Worker, St. Francis Residence, on January 15, 1982.

15) Letter from Dr. Charles Rosenbloom, to the Office of Disability Determination, dated October 14, 1981.

16) Telephone Interview with Linda Breslin, Deputy Director of Treatment Services, South Beach Psychiatric Center on January 18, 1982.

17) Ibid.

18) Telephone Interview with Pam Pannell, Senior Residence Counselor, Washington Heights-West Harlem Inwood Mental Health Council, on December 22, 1981 and January 5, 1982.

19) Telephone Interview with Jane Michele, Director of Day Program, The Bridge, Inc., on December 29, 1981 and January 13, 1982.

20) Telephone Interview with Dr. Itamar Salaman, Director, Soundview-Throgs Neck Community Mental Health Center, on January 6, 1982.

21) Telephone Interview with Margaret Murphy, Human Resources Coordinator, Transitional Services, on December 29 & 30, 1981 and January 5 & 6, 1982.

22) Telephone Interview with Ginny Gerbino, M.D., Attending Psychiatrist, Kings County Hospital, on January 7, 1982.

23) Telephone Interview with Roger Brunswick, M.D., Medical Director, The Bridge, Inc., on January 8. 1982.

24) Supreme Ct., N.Y. County, Index No. 42582-79.

25) Telephone Interview with Robert Hayes, Staff Attorney for the Coalition for the Homeless, on January 12, 1982.

26) Interview with May Blatt, Director of the New York City Regional Office of the Office of Disability Determination.

27) Telephone Interview with Joseph Berkman, Social Worker, Transitional Services, on January 12, 1982.

28) Telephone Interview with May Blatt. See Footnote 26.

29) Telephone Interview with Catherine Meany, Clinical Coordinator, Adult Outpatient Clinic, Soundview-Throgs Neck Community Mental Health Center, on January 13, 1982.

30) Telephone Interview with Linda Breslin. See Footnote 16.

31) Telephone Interview with Lloyd Moses and May Blatt. See Footnotes 6 & 26.

32) Telephone Interview with Lloyd Moses. See Footnote 6.

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[Note.—Appendix retained in subcommittee files.]

American Psychiatric Association
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May 28, 1982

JUN 3 '82

Honorable William Cohen
Chairman
Subcommittee on Oversight of Government Management
Governmental Affairs Committee
506 Carroll Arms
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, I am pleased to present our views and concerns to the Subcommittee regarding the Administration's ongoing efforts to review the current Social Security Disability Insurance (SSDI) rolls. We are very much aware that periodic review of disability cases is necessary not only to reduce fraud and abuse, but also to confirm that SSDI recipients continue to meet eligibility requirements and remain unable to work. However, the Administration's current approach, in an apparent excess of fervor to reduce Federal expenditures, we believe, is contrary to both the letter and spirit of the careful review that was mandated by Congress in the Social Security Disability Amendment of 1980. Moreover, it is being conducted in a manner contrary to sound medical practice. Not only is the program administratively confusing and awkward for the recipients, physicians, state officials and judges involved in it, but it works a special hardship upon the mental ill SSDI recipients who, by virtue of their illness itself, are particulary vulnerable.

## The Situation

In March, 1981, the Social Security Administration began an accelerated review of the claims of people receiving SSDI benefits, a review which Congress mandated be conducted beginning January, 1982. In FY 1982, the Administration hopes to complete 520,000 such reviews, as contrasted to 200,000 conducted in FY 1980. According to a Social Security Administration document of March 11, 1981, OMB "proposed through improved and tightened management of the continuing disability process, that SSA find a way to save the trust funds an additional $200 million in savings in 1982" (emphasis supplied). These continuing disability reviews (CDIs) undertaken since that time, constitute the SSA response to the OMB directive. Among the means of achieving the OMB savings, again according to the SSA document, were to: increase the required number of cases states must review each month (adding 20,000 further cases monthly beginning May 1981, and upping that number to 31,000 further cases monthly in FY 1982); targeting the non-permanently disabled SSDI recipients over review of disabled SSI recipients, since the potential savings from the SSDI cases would be greater; and defer the requirement of personalized denial notices (mandated by law) to "free personnel to concentrate on reviewing disability claims."

What these recommendations have led to has been a nightmare for the state level review agencies. Those agencies, charged with the initial review (as well as with the first level reconsideration of disputed denials), are under tremendous pressure, without adequate time to "gear up" and without adequate staff to handle the increased review load. As a result, reviews are often perfunctory, without adequate medical evidence and with insufficient attention to individual problems. Indeed, the SSA directive regarding the relocation of individuals from producing personalized denial notices into handling the review process, highlights a deeply disturbing component of the problem: staff who are inadequately trained to read and evaluate appropriately medical records submitted (when time permits) by the attending physician. Further, the SSA has argued that by beginning its review process nine months earlier, it has actually spread the new workload imposed on the state agencies out over a greater time frame, thereby easing their burden. However, the evidence is to the contrary. The impact of institution of the reviews in FY 1981, rather than mid-way through FY 1982, has merely added a full year's worth of additional reviews to the state agencies' already overburdened workload. It is hard to believe that, with this increased volume, any examiner, even one who is well trained, could give appropriate time and attention to the medical and other documents comprising an SSDI recipient's claims record. Further, the increased workload of those physicians providing consultative evaluations assures that insufficient time can be given to permit a thorough physical and mental evaluation of recipients undergoing the CDI review.

## The Mentally Ill

The nightmare is even greater for the SSDI recipient, and specifically the mentally ill SSDI recipient. The review procedures are not designed to recognize the very special limitations of these SSDI recipients. When a case is pulled for CDI review, the state agency mails the disability recipient a three-page form seeking detailed information about his or her medical condition and employability. If this form is not completed and returned within 35 days of mailing, benefits are often terminated.

Many of the mentally ill under psychiatric care, capable of living in community-based settings as long as they receive proper medication to control their symptomology, but legitimately disabled, are unable to understand that their only source of income is being threatened. They often do not understand the complexity of the forms, or the necessity of such forms being completed. They either neglect to return the forms, or to complete them adequately and, as a directed result of their disabilities, lose their monthly support (a sum far lower than that associated with hospitalization, often the only recourse when SSDI benefits are terminiated). The problem is compounded by the failure to provide the appropriate follow-up in cases in which forms are not completed, to attempt to ascertain why such form was not returned, to seek the advise and counsel of an attending physician who has previously attested to the continuing disability of such person.

Moreover, given the nature of mental illness itself, it is often inappropriate if not impossible to receive an accurate self-evaluation by a mentally ill SSDI recipient using such forms. It is the very nature of the illness which causes a patient to deny or distort the medical significance of such illness. In a sense, the completion of the CDI form requires a person to make statements about him or herself which, based upon the serious psychiatric, as opposed to physical, nature of the illness, are almost by definition going to be inaccurate.

A hypothetical example of a mentally ill disability recipient's reaction to the receipt of a notice of proposed termination may be instructive in light of the foregoing:

Mrs. X, age 47, is a chronic schizophrenic. She has spent the majority of her life in state institutions, but was deinstitutionalized 5 years ago to a halfway house. She has been maintained on psychotropic medication, which has assured that her symptoms are not obviously disruptive to those around her, but has not "cured" the symptoms. She has been determined to be medically disabled and not capable of substantial gainful employment. She thus has been eligible for and has received SSDI benefits. She has sought employment, but has been unable to find such employment, and remains delusional, though not overtly evidencing her symptoms in her outward demeanor. She continues to hear voices, and it unable to devote any concentration to any job. She receives a notice that a CDI is to be conducted and is instructed to complete the three-page form. As is the case with many of the deinstitutionalized chronically mentally ill, she does not wish to be rehospitalized. She fears that unless she proves that she is "well" and "employed" on the form, that she will be recommitted to a state institution. Thus, she completes the form inappropriately, indicating that she has no physical or mental impairment, and that she has sought employment. (Indeed given the nature of the illness, she may actually believe this to be true). She may even "create" a work history. Her disability benefits are then terminated, based upon her report of wellness. She is reinstitutionalized.

What we find disturbing about the CDI process is not only the apparent disregard of the special and complex nature of mental illness in this initial data-gathering, but also that the case record of a current SSDI recipient is wholly discounted in the CDI process. We understand from SSA that when a CDI is undertaken, evidence must be gathered de novo, as if no prior history of disability existed. We find the disregard of an existing medical history to stand in clear opposition to procedures assuring a full and sound medical evaluation. Its redevelopment, upon notice of a CDI, places an undue hardship upon the patient and his or her treating physician, if one exists.

Perhaps it is the combination of these two matters, coupled with the heavy reliance upon SSA directives regarding the CDI procedures (as contrasted to the statute and regulations with which the directives, such as the POMs, are not always in accord) which has led to the termination of the mentally ill from the SSDI rolls at a rate of 30 percent, while they represent only 11 percent of recipients.

We have received reports from members of the APA that their severely ill patients now receiving SSDI benefits are being closely scrutinized by the state agencies responsible for SSDI review and, in a number of cases, benefits have been terminated, contrary to the opinion of the consulting physician. (See attached letter). It is unclear whether consultative evaluations were conducted. Were such evaluations conducted, however, the evidence presented was probably in conflict with that of the attending physician, and the patient was terminated from the rolls without regard to the report of the treating physician (notwithstanding an appeals court ruling that special consideration be given to the reports from such treating physicians - Dav V. Weinberger, 522 F. 2nd 1155 (9th Cir. 1975). It is also entirely possible that the recipient did not appear for such consultative evaluation, often held in a single centrally-located place in the state. This would not be particularly unusual for a mentally ill SSDI recipient, particularly since he or she may well continue to deny his or her illness.

## The Process

Although denial of disability benefits can be appealed, the process does not seek to maintain the SSDI recipient in the community during that period. SSDI recipients lose all benefits shortly after receiving a termination notice -- including Medicare benefits (which they cannot receive until on the DI rolls for two full years). During the time their appeal is pending, which, notwithstanding a court-ordered 165-day time limit between termination and appeal can often be as long as a year, the former recipient receives no benefits. Even it benefits are then reinstated, many severely disabled individuals will have already lost their homes or will have been forced to discontinue residential or treatment programs.

Many terminated recipients do not know their right to appeal to an Administrative Law Judge (ALJ); many do not have the capacity to do so; and many have already been reinstitutionalized and cannot do so. We do know, however, that many of those individuals seeking redress at the ALJ level -- over 60 percent of them -- have their benefits restored. We have woundered about the difference between the initial processes (including reconsideration) and the ALJ appeal. The answers appear to be several:

- an ALJ has a face-to-face meeting with the recipient, and is thereby better able to review aspects of demeanor, affect, functional ability that are easily visible to the eye;
- the patient may well have deteriorated in the period intervening between reconsideration and the ALJ hearing;
- and most important, the ALJ is bound by the statute and regulations, whereas the state level officers rely upon the POMs and other SSA directives which are not necessarily consistent with either the law or regulations.

## The Response

We know that Congressional legislation, H.R. 6181, seeks to resolve several of these discrepancies which work first to the recipients disadvantage but later to his or her advantage. However, we believe that the legislation fails in several respects, particularly regarding both means of resolving the differing baseline policy documents governing ALJ versus state agency decision-making, and its requisite that the medical record be closed at the reconsideration level.

We are also aware that SSA has indicated that it is developing a consolidated series of standards for use at all levels of CDI and SSDI evaluation. We are equally troubled by this approach.

Neither the proposed legislation nor the SSA efforts to develop a standardized policy will provide for public comment -- including comment by the medical profession such as psychiatry -- on the validity of the criteria being established for eligibility determinations. The legislation would make all currently-used documents binding upon all reviewers; the SSA would have us accept a new package which would substitute for statute, regulations and all other less formal but nevertheless currently binding documents.

The APA suggests that it is most appropriate for whatever documents are used for SSDI or CDI determinations to be subject to the Administrative Practices Act requirements regarding Federal Register publication and public comment. Medical professionals, and the organizations that represent them, are well qualified to help ascertain the appropriateness of such documents, and their potential strengths and weaknesses in reviewing particularly complex disabilities such as mental illness.

Moreover, we would strongly recommend that CDI reviews conducted upon an individual claiming mental illness as a primary disability be required to include: (1) a direct outreach effort to secure the information contained in the self-evaluation document sent when the CDI is undertaken, which should include a face-to-face meeting with a state examiner; (2) a required full consultative evaluation conducted by a psychiatrist, who is singularly qualified to perform such evaluations of a psychiatrically ill SSDI recipient; and (3) a full review of the recipient's medical history to date, as provided by the attending physician and existing SSDI case records.

The costs associated with what we believe to be a more appropriate initial CDI are insignificant when contrasted to the increased costs of the appeals process. The SSDI recipient's approximately $15 daily benefit from his or her continued eligibility is insignificant when compared to the $100 to $500 a day it costs to maintain a disabled person in a hospital. The costs associated with a more thorough, accurate review of a recipient's right to remain on the DI rolls is small when contrasted to the potential future costs to either the health care or criminal justice system into which such an individual would likely be diverted absent his or her disability check.

The APA urges, on behalf of psychiatrists and those patients we treat, that an immediate halt be brought to the wholesale SSA activities to remove patients wholesale from the SSDI rolls, until legislative remedies to the detrimental situation now confronting hundreds of thousands of our nation's least protected individuals can be adopted. We hope that current Congressional efforts will be considered a springboard for reform, but urge that the changes we have proposed herein be incorporated in any legislation adopted by the Congress on behalf of the mentally and physically disabled.

I hope you will make this statement part of your hearing record on this most important issue.

Sincerely,

James Folsom M.D.

James Folsom, M.D.
Chairman
Committee on Rehabilitation
American Psychiatric Association

JF/TF/aw

## STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION

This statement is submitted on behalf of the National Mental Health Association (NMHA) a nationwide, voluntary non-governmental organization dedicated to the promotion of mental health, the prevention of mental illness and the improved care and treatment of the mentally ill. NMHA's 850 local chapters and statewide divisions and its more than one million citizen members and volunteers work toward these goals through a wide range of activities in social action, education, advocacy and information.

The NMHA has serious concerns about the current Social Security disability review and appeals system. Also, NMHA has some specific suggestions for improving the disability review and appeals process which will be expressed in this testimony.

As a result of a 1980 law, the Social Security Administration (SSA) has begun an accelerated review of individuals receiving benefits under the Federal Disability Programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Periodic review is necessary to confirm that recipients continue to meet eligibility requirements and are still unable to work. These stepped up reviews are expected to save $200 million in 1982 by making drastic reductions in the disability rolls, according to an SSA document.

Reviews are often perfunctory, without adequate medical evidence and with insufficient attention to individual problems, as documented in the enclosed case examples. Currently, a significant number of psychiatric patients who clinically manifest an inability to engage in consistent substantial gainful activity are being denied disability benefits. According to Chicago's Acting Regional Commissioner of SSA, SSA field offices are concerned because:

> "individuals whom (SSA field offices) consider to be obviously disabled, based upon observed bizarre and unusual behavior and interviews in the SSA district offices, are denied".

Large numbers of schizophrenic and other chronically mentally ill persons who have been receiving disability benefits for years are now being terminated. Also a greatly reduced number of new applicants are being judged eligible, thus preventing many chronically mentally ill persons from leaving institutions. An SSA medical consultant has written that many individuals with serious residual symptoms (mostly persons with chronic schizophrenia) who have made a marginal adjustment to every day demands of semi-independent living outside of a mental hospital are being denied benefits, unable to meet stringent new reviews of their impairments. This consultant pointed out that it is:

> "practically impossible to (meet the criteria) for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization. In fact, an individual may be commitable due to mental illness according to the state's mental health codes, and yet found capable of 'unskilled work' utilizing disability standards."

The case examples attached to our report, and the numerous calls and contacts which Mental Health Associations across the country are receiving on this issue, make it very clear to NMHA that something is seriously wrong with the current operation of the system. It is NMHA's contention that the numerous cases which we have become aware of which have been decided against the mentally disabled person indicate that SSA procedures are now acting to deny benefits to the truly disabled. This is supported by the extremely high rate of reversal at the appeals level.

Specifically, NMHA has charged that the SSA reviews have three significant problems. First, the process of review is very perfunctory. Individuals are terminated without reference to recommendations of attending physicians, but merely upon a review of their files. Second, there is inadequate medical evidence used in the review process. Individuals are given less than thorough examinations by medical consultants. It is particularly difficult to judge whether a chronically mentally ill person can work, but such recommendations are made after brief psychiatric consultations. And third, the criteria used for deciding whether an individual is eligible are not related to employability. For example, individuals that are determined by rehabilitation agencies to be unemployable have been judged by SSA criteria to be ineligible for disability because they can work.

The Director of the Wisconsin Bureau of Social Security Disability Insurance stated:

> "Current adjudicative climate involving mental impairments seems to be one of deny, deny, deny...based upon a most minimal possible understanding of mental impairments...and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capacity of going out in the competitive world and obtaining and holding a job...As an individual with 17 years of experience in the Disability Program...the current review criteria, in many instances (are) ludicrous and indefensible."

In an attempt to right the injustices being done to mentally ill persons by these review processes, the NMHA urges:

- Congressional hearings including field hearings, to address the full array of issues in the disability review process;
- a General Accounting Office investigation of the Social Security Administration's practices with respect to determining continued eligibility so as to examine the immediate and long-range impact of current SSA practices on beneficiaries and on Federal, state and local governments;
- that beneficiaries not be terminated prior to a full and careful review of the merits of their case by appropriately qualified professionals;
- that mentally disabled beneficiaries and those who are homebound be provided with personal assistance (and home visits if necessary) throughout the review process.

In conclusion, gross injustices are being administered to the mentally ill through the current review and appeals system. It is extremely urgent that some action be taken to avoid such in the future. The NMHA urges the Subcommittee to take a thorough look at the effects this review and appeals system is having on the mentally disabled individuals, and quickly try to correct the injustices of this system.

# TESTIMONY
# BEFORE
# OVERSIGHT OF GOVERNMENT SUBCOMMITTEE
# GOVERNMENTAL AFFAIRS COMMITTEE
# OF
# THE UNITED STATES SENATE

May 25, 1982

Presented by:

John Harris,
President,
National Council of SSA
Field Operations Locals

On behalf of:

The American Federation
of Government Employees
(AFL-CIO)

John Harris
185 Fed. Bldg.
316 Robert St.
St. Paul, MN 55101 (612) 725-7931

Mr. Chairman,

My name is John Harris and I am the President of the National Council of Social Security Field Office Locals, an affiliate of the American Federation of Government Employees (AFL-CIO). My organization is the labor union for 35,000 Social Security workers in about 1,300 district, branch and teleservice offices of the Social Security Administration. The workers I represent are claims representatives, service representatives, clericals and other technicians who take and process Social Security and SSI claims and post-entitlement changes to benefits. Because of our daily personal contact with the public that we serve, we are uniquely aware of the impact which the Social Security programs and administration has on them. For us, that impact—often reduced to a drill of statistics, measuring numbers of people and numbers of dollars—is visible and real. The prospect of 700,000 people cut from disability rolls is for us the vision of men and women sitting before us yesterday, today and tomorrow—people confused, angry, frightened, impoverished and helpless. We help them appeal the decision to stop their benefits and they ask us how long it will take to get their benefits back. We tell them that the appeals process is backlogged and that it may take 6 months to a year, and they ask us—hopelessly, rhetorically but sincerely—how will they live in the meantime. We refer them to local welfare offices, knowing that for many assistance is not available. And we can do no more.

In some terrible cases we later send these same people notices that they were overpaid because their disability benefits should have stopped before they actually did and under our regulations we are told to demand immediate and full repayment. We know how this will affect them and so we are not surprised when they show up at our desks again. We are ashamed of a program that treats people so, but we are obliged to tell them that failure to repay can result in legal action against them and we are told that we shouldn't bring up the possibility of waiving recovery of the overpayment unless they do, that our main objective must be the collection of this so-called debt and preferably in cash and fast. It is not hard for you to imagine how ordinary people feel about these circumstances, and it is such things that have caused among my workers a common condition of emotional exhaustion which SSA's own studies acknowledge exceeds toleration.

When the numbers of people affected by a tragedy are great, the shock of the tragedy is numbing; the sheer greatness of the tragedy seems beyond the mind's grasp. For my people who are its daily witness, the numbers come before them one by one, day after day and it is impossible for them not to feel the measure of sadness and suffering which cutting these people off from their livelihood means. Yet against the relentlessness of these repeated tragedies, even we who see them and talk to them and hear them begin to see them too just as numbers, as one among thousands. In our budget process as a government, we seem more and more inclined to see our people as numbers, as dollars and cents. Rights to benefits seem more and more a trade off against some inhuman economic dialectic, a part of the scheme of deficits and revenues without regard to the individual, and programs like Social Security and SSI have become more and more blind to the people it is our mission to serve, who have become lost in balance sheets. The accuracy and timeliness of people's benefits is traded against the administrative costs to make those benefits accurate and timely; the equity of the program is traded against the convenience of the bureaucracy; the need for benefits is traded against the cost of benefits, and the wealth of our nation is measured less and less by our ability to fairly share that wealth, and more and more seems measured by our willingness to restrict the share of wealth which those with the least possess.

I am asked to testify to the impact of current practices in the administration of the disability program. While what I have just said goes beyond that impact and to the very heart of the problems which confront SSA in all its administration, what is happening in the disability program eptiomized what I have said.

Ideally we would expect the disability program to be guided by improving administration, responding to the accumulated experience of years and correcting upon its errors as it goes, like the development of an invention which more and more approximates the wishes of its inventor. In fact, the program has changed and vacilated by altogether other motives, steered more often by expedients than sound management, buffeted by politics, administrative and legislative changes, and unrealistic budgets. It is commonly held that the program was better administered in the early 1970's when up to 100% of all initial allowances were reviewed by SSA and the number of appeals was a small fraction of what it is today. Over the years a number of things occurred which caused many to doubt the integrity of the program. In 1972 SSA stopped doing pre-effectuation reviews of claims and started doing a small sample of cases. Backlogs in pending black lung claims demanded immediate action and staffing was insufficient to continue the high rate of claims review, if SSA was to process these black lung claims many of which were over 1 year old. While the rate of accuracy of state agencies seemed generally good enough to justify this changes (or at least to tolerate the expedient) the state agencies had been used to more direct control and guidance in the case handing than they were to receive from then on. There were published regulations guiding their determinations, but detailed program instructions were lacking, because of course total review by SSA made that kind of instruction unnecessary. At about this time SSA reorganized its management and further diminished central office control by regionalizing its administration of the disability program. During the years that followed, the rates of allowances, error rates and case handling varied greatly among the state agencies. Instructions on case handling also varied among the SSA regional offices but often there were no consistent case handling policies at all.

In 1974 SSA took on the administration of SSI, virtually doubling its workload in disability claims. Staffing was not sufficient from the beginning in either SSA or the state agencies For the state agencies this resulted in huge backlogs and record high delays in processing the case loads. Staffing was hired but only slowly gained expertise, and it is known that quality suffered in the years of 1974-1976 while adjustment to the new program took hold. Still reeling from black lung, the appeals process faced new and increasing workloads and they also suffered in increasing delays in processing times and presumably also in quality, although data is incomplete. For its part SSA was so overburdened that they canceled and postponed many medical reexaminations and CDI's that they had scheduled and the overall processing time for disability cases grew and grew. By 1978 the workloads began to level off and processing times began to improve. Congress, however, reacting to the crisis in SSA commenced to investigate and ultimately amend the law in order to shore up the system.

Cursory reports of GAO more recently showed that perhaps 20% of those receiving disability benefits were ineligible. Those reports were not very reliable but with the explosion of applications and allowances in the years 1974-1977 and the known program mismanagement, the figures of GAO could not be dismissed.

Moreover, the disability regulations had not been updated since 1968 and there were reasons to believe that some of them were invalid. Instructions to state agencies still were not uniform, there were no effective administrative controls over state agencies, and some policies on disability determinations seemed inconsistent with the law and regulations.

All of these things, as we say, set the stage for major changes in the program in 1978-1979. But interestingly there still is no real evidence that during these years of apparent mismanagement great numbers of people were improperly allowed benefits. In fact, the rate of allowances in the years 1974 through 1977 was lower than previous years. But the total numbers of people allowed increased because the numbers of applicants increased. The first real attention by Congress to the problems was recognition that more disability funds were needed and so the amendments of 1977 increased the share of DI in FICA taxes at the expense of OASI. It was this initial concern for the trust funds that prompted SSA initiatives to "tighten up" the disability program. New regulations were promulgated in 1978-79 which were for the most part much more stringent and demanded more medical evidence. Program Operations Manuals (POMS), establishing new and uniform standards of adjudication, were implemented in 1977-78, and these too gradually effected change in the "climate of adjudication." By narrowing the application of the regulations as well as narrowing the regulations themselves, the number of allowances plunged; currently that rate of allowance is at an historical low and the total number of persons allowed per year is lower now than in 1970 even though the number of applications is several hundred thousand higher.

In 1980 Congress enacted major disability amendments which further "tightened" the program. Administrative reviews of claims before payment was restored. Periodic reviews of disabilities was mandated by law. Performance standards for the state agencies were authorized so that SSA could shut down a state agency that didn't follow its policies or meet its objectives. In a sense these legislative changes were belated. If there had been a period when these mandates were necessary (1974-1977) that period had now passed and the administration, responding to concerns for the trust funds, has already "tightened" its administration. This legislation, however, served to encourage those measures and enhanced them and now served as aegis to the soon coming speed-up to remove people from the rolls.

In the meantime concern grew that the administrative, regulatory and legislative changes were causing too many to be disallowed. If perhaps too many were allowed during the mid-70's, it now seemed too many were disallowed. In terms of the number of allowances per 1,000 in insured status, allowances were at an all time low of less than 4 per 1,000, half of what it once was. More and more denials were being appealed. Where those appeals were made directly to the state agencies, fewer and fewer allowances were resulting, reflecting the tightening up of disability determinations. But if appealed to administrative law judges at hearings, more and more were allowed. For many the ALJ became the only hope for a fair and just decision; to the advocate, this is axiomatic. To the workers, the current climate of adjudication mades no sense. State agency decisions seem harsh and unreasonable; we have all witnessed cases in which the obviously disabled are turned down and we have all gotten to the point of encouraging appeals and urging claimants to contact their congressmen.

Meanwhile, legislation pends which would attemp to bring the ALJ under the same rules of the state agencies and limit their authority to hear and receive evidence. If it is assumed that the state agency decisions are now better made, better regulated, and more accurate, the decisions of the ALJ's seem out of line. But we reject that assumption. It seems to us that SSA's recent "tightening" of disability procedures is just part of its historical problems in management, a reaction to criticism of past errors that now errs too far in the other direction. The current regulations and practices arose with an intense and fervent motive to reduce disability allowances, but they are not then more accurate. If SSA's decisions were accurate, we would assume that those denied benefits are capable of substantial gainful activity. Our own personal observations made us doubt this. We have since found that SSA's own studies show that most disallowed disability benefits never go back to work, only about 10% ever regain substantial gainful work activity. Under the circumstances, the fact that the ALJ decisions are so different from the state agencies makes us doubt the accuracy of the ALJ determinations less than we doubt the accuracy of the state agency determinations.

Given this background we view the current acceleration of cessations with suspicion. State agency decisions are much more stringent and narrow than they were, seem less and less valid or fair. So how can these CDI's be fair? Moreover, the way in which the CDI's have been conducted makes us feel that those being ceased from benefits are victims of an unjust and heartless administration.

Increased periodic reviews were required by law but were not to begin until 1982. But in the budget proposals of 1981 OMB called for $200 million in savings from "tightening" disability administration. Acting under this SSA planned for accelerating CDI's, savings were to be gotten by terminating benefits; the number to be reviewed was based on the expectation that 50% reviewed would be terminated and the total number of terminations needed to get $200 million was used to determine how many would be subject to CDI's.

After starting the accelerated CDI's in March 1981, SSA then adopted CDI case selection criteria to maximize a high dollar return for each termination. Using profiles of benefit characteristics, SSA selected those beneficiaries who had high benefits (\$400 or more), had families receiving benefits, or were under age 50 and so expected to receive benefits over a long term. Medical conditions likely to recover were not identified but so-called obviously permanent impairments were supposed to be screened out. In many cases, however, permanent impairments were not screened out. Almost equal to OMB expectation, SSA is now terminating about 47% of those they review. Interestingly, this rate of terminations is twice as high as the original rate predicted by SSA's data on these profiles. Based on this performance and the budgeted CDI's for 1982-1983, 720,000 to 800,000 terminations are projected. The acceleration of CDI's seems cynical, focused as it is on quickly terminating those whose benefits are highest. Certainly it has had adverse impact on SSA in many ways: case loads are higher now in state agencies than ever before, even greater than the years of crisis in 1974-1977; most state agencies are not meeting the processing times goals set for them by SSA and initial claims are taking several weeks longer to make final decisions. Appeals are backlogged; case loads among ALJ's have more than doubled in a year and we are witnessing delays in hearings the likes of which we haven't seen since the worst days in 1972-1977. And too the public image of SSA has in no small way been damaged.

But all this begs the question, are those being terminated really ineligible? By anecdote there seems considerable evidence that many of those being cut from benefits ought not to be. You have all received complaints from your constituents. We have all seen stories in the media and there is a growing group of citizens who are protesting these terminations. Among my own people personal observation is that inordinately high numbers of the mentally ill and mentally retarded are being cut off from benefits and because we know these people we see how few of them are able to adjust; practically none have jobs, most are utterly dependent on the welfare system for food, shelter and medicine. Many are being reinstitutionalized.

More recently we learned that SSA has changed its policies on evaluating mental impairments and this seems reflected in these terminations. SSA's initial projection was that perhaps only 10% of these were ineligible; since its change in rules, projections now seem doubled. Our communications with state agency workers and our own quality assurance workers confirms our sense that the disability program has been tightened so much that now many severly disabled people are being unfairly denied benefits and unjustly terminated. As one state agency official said to me recently, the way the regulations are now being applied you've got to be very nearly dead or a mental vegetable to get benefits.

The Commissioner of Social Security recently announced statistical findings that over 30% of those getting benefits are ineligible. This data was based on the second of two studies by the office of assessment. The first study showed that 21% were ineligible and some of our workers reported that the second study seemed slanted, as though central office was seeking to increase the number of ineligibles by applying the regulations too narrowly. Be that as it may, the study shows some internal inconsistencies which makes us wonder about its reliability. In the first place, there was a high rate of disagreement among those who did the reviews—about 21% of the cases were in dispute. Secondly, most of the findings of ineligibility were cases in which the original decision to pay benefits was said to be wrong; cases in which the beneficiary was said to have medically recovered because of improvement in his condition only account for about 35% of the total number of ineligibles. Thirdly, cases of ineligibility are about equally divided between those entitled in the last 3 years as those entitled before that. We are not apparently finding ineligibles predominantly among those who came on the rolls during 1974-1977 when the program supposedly allowed too many people.

The data suggests that SSA is applying criteria to these cases that were not applied before, that the "tightening up" of the disability program is causing terminations of people who when judged by standards at that time were clearly eligible but now are not, even though their medical condition has not changed. On its face, the rate of 30% ineligibility seems much too high. The error rate for state agencies has never been that high. Typically it has been roughly 10%, and that rate included payment errots and documentation errors combined, with actual erroneous payments constituting only about 1/3 or 3-4%. Even with a liberal reckoning that half of those ineligible are the result of medical improvements, at least half of all appeals decisions and maybe double the historical rate of state agency errors would have to be taken into account to come up with a 30% rate of ineligibility.

Two things are certain: The Commissioner fully intends to terminate 30% of those on the rolls and the current practices will readily deliver those terminations, and most of those terminated have no other livelihood, will not go back to work, and do not have much hope for other assistance.

The committee has asked for suggestions on legislation to deal with these problems. These are provided here as an exhibit. Some sectional analysis will be submitted at a later date.

I hope this testimony proves useful and that the Congress will consider our proposals in its deliberations.

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[Note.—Attachment "Proposals to Restore Integrity to Disability Procedures" retained in subcommittee files.]

P. EOPLE
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4732 South Central Avenue
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May 18, 1982

STATEMENT FOR ENTRY INTO THE HEARING RECORD OF THE SENATE SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT'S HEARING ON THE SOCIAL SECURITY ADMINISTRATION'S PROCESS FOR REVIEWING DISABILITY BENEFIT ELIGIBILITY, MAY 25, 1982.

People United for Self Help, a small social service agency which since 1974 has assisted nearly 3,000 disabled clients who have been denied benefits, appreciates this opportunity to present its experience regarding the impact of the increased volume of case reviews on the quality of the disability review and appeals system.

Certainly, the increased reviews and high percentage of terminations have impacted our caseload, both in new clients and in reopened cases, to the extent that we have had to focus our services on the most economically needy of these claimants. Further, we find that many of these individuals are so traumatized by the sudden termination, that they do not request reconsideration or file for a hearing. The implication of the statement that 50 percent do not appeal a termination decision because they are improved and capable of gainful employment is completely misleading.

The high rate of terminations upon review simply highlights the disparity of the decision-making processes. Disability Determination Services is unable to consider 1) combinations of impairments, treating the thirteen different body systems as unrelated to one another, 2) the reality of pain, as it cannot be substantiated by an X-ray or lab test, and 3) stress, depression, and mental illness as significant factors in unemployability. Conversely, the Administrative Law Judge is able to hear testimony, ask questions, secure additional information, and review the claim in comprehensive totality.

For example: One P.U.S.H. client, 48 years of age, has been on Social Security DIB benefits for 8 years, following a back injury which prevented his return to previous employment at a cotton gin. At the time of the approved decision, his file showed that he had an IQ of 56, a conversion reaction, and minimally limiting congential abnormalities of feet and spine. At the review, Disability Determination found he had an IQ of 62, but still had the conversion reaction, still could not read or write, and was still unacceptable for Vocational Rehabilitation. With the cessation of benefits of $550 per month (based on his earnings and contributions to the Disability Insurance program) this individual who was receiving no other social benefits, has had to go on State General Assistance, Food Stamps, and county health care for the indigent. Although it could be stated that his IQ improved from 56 to 62, this condition would appear to continue to meet the listings (IQ of 69 or less with another significant impairment). Therefore, it is most likely that his benefits will be reinstated at the hearing, with back benefits paid to the date of termination. What a costly process for the taxpayers, at all levels of government, and what a painful experience for the individual and family!

Within our case records are numerous examples of the hardships endured by the review/termination/reinstatement process. Extensive delays in reaching a determination, repeated hospitalizations during this time, mounting debts and inability to maintain basic needs, result in frustration, fear, and even death. A 59 year old man, formerly a farm laborer, was hurt on the job and never recovered from his back injury. When workmen's compensation ceased he began receiving Social Security disability in 1975. His benefits stopped in December of 1981, but he was found to be ineligible since November of 1980, resulting in a large overpayment. As a lumbar epidural venogram in February of 1981 conclusively showed a herniation of L-5, S-1, and he was unable to sit for more than 15 minutes or stand for longer than 30 minutes, he appeared to meet the disability listings. He went to a hearing in early March but died of a sudden heart attack before the decision, restoring him to benefits, was rendered.

P.U.S.H. urges the Sub-Committee to consider the following recommendations for remedying or improving the disability review and appeals process:

1) Focus study and research on the inadequacy of the disability determination system rather than on the individual hearing process. Certainly, a system can be devised to determine more accurately at the early stages of the claims process whether or not a person qualifies for benefits.

   The disabled person who applies for benefits generally considers those payments for FICA as an insurance contract with the federal government for that proverbial rainy day when, because of illness or age, gainful employment is not possible. By focussing attention on the hearing decisions—made after personal and individualized assessments have been made by a well-qualified lawyer/Administrative Law Judge—Social Security is giving the impression that denying claims is "right" and approving them is "wrong." This assumption permeates so much of the rule-making and instruction of Social Security. It must be changed to keep faith with those disabled workers who file applications and are denied or terminated while still not medically improved.

   According to the Arizona Labor Market Information Annual Planning Report, based on the 1980 Census, there are 71,570 physically disabled persons in the state who are unable to work. According to 1979 Social Security figures, there were only 52,000 individuals receiving either DIB or SSI in Arizona. It is entirely possible that nearly 20,000 (27%) additional beneficiaries should be on the roles.

2) For those who have been on benefits for eight to ten or more years, the review process should begin a year in advance with a notice referring the beneficiary to vocational rehabilitation. Certainly, this process would enable and encourage the disabled to plan and work for the future.

   Many of the people we are seeing at termination are individuals who were approved for benefits before the current strict application of Listings and the Vocational Regulations. While they have been on benefits, no one has suggested that retraining for potential return to the work force may be considered. When they do receive a termination letter after years on disability benefits, the impact is akin to the long-time employee getting laid off: all these years, the person has had a job--that of being disabled--and suddenly the "lay off" descends. Psychologically, the person must react to a bureaucratic decision with which there is no agreement, and without having a transition time to prepare for this event.

3) The vocational rehabilitation system should be strengthened and expanded to provide access to retraining and employment for the disabled who do not meet the strict standards of the Social Security Administration.

   Under the budgetary constraints in operation, Vocational Rehabilitation funding has been cut significantly. If those currently receiving benefits do not continue to be so severely disabled as to be continued on benefits, some provision must be made for effective Vocational Rehab assessments and training. While we have not kept statistics, it is our impression that very few of the disabled who have been denied disability benefits, or who have been terminated, are being accepted as feasible for rehabilitation. If this is a common experience across the country, it points to the need for greater integration of decision-making and services for the most cost-effective utilization of time and personnel.

P.U.S.H., in conjunction with a volunteer multi-disciplinary group, called the Social Security Advocates, is sponsoring a public forum on disability benefit problems on Friday, May 21, 1982. Based on our initial registrations, a high percentage of the individuals planning to participate in this event are termination cases. We anticipate that the transcript of the comments will be completed in time for submission before June 25, 1982, for inclusion in the hearing record.

Sincerely,

Catherine Zandler

Catherine Zandler
Executive Director

P. EOPLE
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JUN 24 '82

June 23, 1982

The Honorable Carl Levin, Ranking Minority Member
Senate Oversight of Government Management Subcommittee
Committee on Governmental Affairs
3306 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Levin:

Enclosed are three copies of the transcript of the proceedings at the Public Forum on Social Security Disability Benefit Problems which was held in Phoenix on May 21, 1982 and sponsored by the Social Security Advocates.

Please enter this information into the record of the hearing on the Social Security Administration's process for reviewing disability benefit eligibility.

We regret that the second half of the Forum is not presented verbatim. As the transcript is prepared by volunteers, we did not have time to complete it so as to meet the deadline for submission of written comments. We did, however, include all of the comments made by individual claimants. We will proceed to complete the transcript which then will include the valuable comments made by a number of private agencies which serve the disabled.

Over 200 persons attended the Forum which we believe offered a great deal of information for the disabled as well as enabling them to present their stories.

Sincerely,

Catherine Zandler

Catherine Zandler
Executive Director

NOTE: Accompanying transcript of the proceedings of the Public Forum on Social Security Disability Benefit Problems held on May 21, 1982, is retained in the subcommittee files.

# STATEMENT

on the

# SOCIAL SECURITY ADMINISTRATION'S CONTINUING DISABILITY INVESTIGATIONS (CDIs)

Respectfully Submitted

to the

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

COMMITTEE ON GOVERNMENTAL AFFAIRS

U.S. SENATE

by

The Save Our Security Coalition

Tuesday, May 25, 1982

The Save Our Security (SOS) Coalition is comprised of over 100 organizations concerned about our nation's Social Security system. The leaders of SOS include two former Secretaries of Health, Education and Welfare (HEW), several former Commissioners of the Social Security Administration (SSA) and a number of former members of Congress. It is a bi-partisan coalition.

SOS was formed to protect and defend the most important social invention in the history of our nation, a program that is absolutely vital to the economic security of workers, their dependents and survivors - our Social Security system.

In March, 1981, the Social Security Administration began a stepped-up review process of disabled beneficiaries. Thousands and thousands of cases were, and continue to be, dumped on state agencies which were unprepared and are without adequate resources to handle such a massive caseload. As a result, the Social Security Administration has since terminated over 106,000 disabled beneficiaries, many of whom are the victims of erroneous decisions based on inadequate reviews.

Our observations of the continuing disability investigation process, its origins, implementation and its effect on Title II and Supplemental Security Income (SSI) recipients lead us to raise one very fundamental question, i.e., are the current terminations based upon a finding of temporary disability from which the beneficiary has recovered, as mandated by the Congress, or do they represent a readjudication of the extent of disability based on a different and even more restrictive definition of disability? Stated differently, does recent experience suggest that the disability definition in the law, which is spelled out in the very extensive Social Security disability regulations, has been amended by administrative fiat without legislative sanction or public awareness? We, in SOS, believe this to be the case.

It is obvious to us that there are forces at work in our country which would use our current economic difficulties to launch an attack on the Social Security system which would erode its effectiveness and ultimately render it ineffectual as the basic framework for the economic security of the American people in retirement and of those for whom total disability or the untimely death of the family breadwinner would otherwise result in economic disaster. Born in the depths of the Great Depression, and dedicated to the principle that never again must the aged, the infirm, widows and orphans be left helpless and hopeless as victims of the business cycle, what a historic travesty it would be for the government of the United States to use the excuse of what is admittedly the most serious economic crisis since those dark days to abrogate that commitment.

The Committee on Economic Security, which developed the original plan for the Social Security system recognized that the program must begin on a modest, relatively conservative basis, and be expanded over time based on experience to cover a much broader range of protection than that initially enacted. It was clearly envisioned from the beginning that the program should eventually be expanded to provide income security and health insurance benefits for the disabled. The eventual enactment of the disability amendments in the early fifties attested to the overwhelming acceptance and support of the system by the public and by public policy makers in the Congress. Paralleling the approach followed in the inception of the basic system, the disability program was introduced on a very modest and conservative basis, and was liberalized and expanded only after the Congress was fully convinced that it was soundly conceived and could be effectively administered. The program, both from a conceptual and an administrative perspective, passed the scrutiny of repeated Congressional reviews and, in the decades of the fifties, sixties and seventies, was extended and liberalized.

From its inception the Social Security system has been administered in an effective manner. We believe that record of sound administration has been characteristic of the Disability Insurance program as it has in all of the Social Security Administration's program responsibilities.

SOS has encouraged Congressional hearings directed towards achieving a better understanding of recent experience in the Disability Insurance program which has resulted in the termination of disability benefits for many thousands of disabled beneficiaries. We applaud the Subcommittee's efforts to look into this matter and to ascertain in a public forum the basis for the recent unprecedented purge of the disability benefit rolls. While we have not done extensive studies of this recent experience, what we have observed greatly troubles us.

It is important to recognize from the outset that the Social Security Disability Insurance program is, and has always been, a very restrictive and conservative program, based upon a definition of disability which requires that the beneficiary must, because of a medical impairment, be unable to engage in substantial gainful activity, and that the level of severity must be expected to persist for at least a year or to result in death. We also know that over the years the public perception of the program has been that, if anything, the program was administered very strictly. It is a fact that the overwhelming majority of those found to be entitled to benefits are never able to return to work. Studies in the past also show that the great majority of those who were turned down as not being as severely disabled as the program requires have not been successful in returning to substantial gainful work.

The Social Security Administration has had in place for many years procedures for identifying beneficiaries who have medical conditions from which they may ultimately recover, and these beneficiaries are scheduled for medical reexaminations. Individuals so identified are given notice when benefits are awarded that since they may recover from their disability they can expect to be requested to undergo a medical reexamination at a future date and that benefits may be terminated if such recovery does in fact occur. Given the stringency of the disability requirements, and the procedures for medical reexamination where recovery may reasonably be anticipated, the recent experience of abrupt terminations based on reevaluation of beneficiaries not so identified is difficult to understand.

We recognize that in the 1980 legislation the Congress directed the Social Security Administration to conduct a much more intensive review of those receiving disability benefits to detect individuals who had only temporary disabilities and to terminate benefits to such individuals who had recovered. Given the unanticipated increases in program costs in the early 1970's, it is understandable that the Congress may have felt such double checking of beneficiary rolls to be a necessary step to assure continuing public confidence in the integrity of the program. However, we see nothing in that legislative provision which would dictate a wholesale purge of the disability benefit rolls, nor is there anything in the legislation which would require that any disability beneficiary should lose entitlement without a clear and unequivocal showing that the medical condition was temporary, that medical recovery has occurred as demonstrated by current medical examination, and that the beneficiary does in fact have the current ability to engage in substantial gainful work. We do not see anything in the legislation which would sanction any procedure which does not give adequate advance notice, require full medical evaluation, and all of the other essential elements of due process including a truly independent review of any adverse findings by an Administrative Law Judge.

In assessing the recent disability termination experience it is important to keep in mind what is known to be historically true with respect to the characteristics of disability beneficiaries. Disability beneficiaries are characteristically in their middle fifties, tend to have less education and more limited work skills than the general population, and the great majority suffer from degenerative diseases associated with the aging process. In other words, characteristically these beneficiaries are growing older and deteriorating medically. Finding a significant percentage of these beneficiaries whose disability has become less severe with the passage of time is indeed surprising.

The Save Our Security Coalition wishes to thank the Subcommittee for taking the time to air the issues which have emerged because of the Social Security Administration's massive terminations of disability beneficiaries. In our opinion, the continuing disability investigation process has been misused, and thousands and thousands of disabled people are suffering needlessly. We urge Congress to take immediate action to remedy the situation and offer our assistance in the formulation of legislative solutions.

815 Jerome Street, Apt. 11
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June 17, 1982

JUN 22 '82

Senate Oversignt of
  Government Management Subcommittee
Committee on Governmental Affairs
3306 Dirksen, Senate Office Bldg.
Washington, D. C., 20510

Re: Letter of May 14, 1982

Dear Chairman Cohen:

I must apologize for getting this letter to you too late for the Committee to consider prior to the hearings. Unfortunately, I was too busy advocating for clients concerning the very thing your Committee is dealing with, i.e., the massive amount of unfair and unjustified disability cuts on the part of the Social Security Administration acting in joint collusion with the State Disability Determination Office.

The letter reflects my own personal views, but evolved from my work experiences. I am a licensed social worker with the Human Resources Department, City of Lansing. I have been with the department eight and one-half years, with the mission to assist the handicapped population of Lansing. In the past three years, I have been involved with representation of claimants before Administrative Law Judges with the Social Security Administration. Even though I am not a lawyer, working in this capacity, I have always been treated with professional dignity and respect by the judges that I have appeared before. I have never met such a fine, patient and fair group of people as exemplified by the Office of Hearings and Appeals here in Lansing.

It has been only in the past year, or year and a half, that I have noticed an increase of cases being "reviewed". The reviews, in my estimation, are without a doubt, very capricious and most of them are withoutmerit. The reviews are done by the local Disability Determination Service (D.D.S.) which is the weakest link in the Social Security Disability process. I say weakest link because many times, the examiners are unskilled, untrained personnel, reinforced by doctors who have retired from private practice.

The Disability Determination Service uses a much stricter criteria for evaluating claimants than is called for by the Act. I am referring to Sections 202, 205, 216, 221, 222, 223, 225, and 1102 of the Social Security Act, as amended. When D.D.S. reviews a case, they do not take into consideration such things as age, education, and work experience. These three factors, plus the overriding disabling characteristics, directly affect the determination of the claimant's ability to participate in "substantial, gainful activity." In addition, the claims examiner is supposed to send our interrogatories to doctors and consulting physicians. Even if this is done, if they do not happen to receive the interrogatories back from the physicians within a thirty-day period, the case is automatically denied. Furthermore, the claims examiners are criticized if they approve a claimant in that they have to spend more time in explaining to the Administration why they approved a claimant than they do if they disapprove one.

D.D.S. has the attitude that is it not up to them to fully develop a case. That, they say, is up to the Administrative Law Judges (who D.D.S. hate with a passion), and yet, if D.D.S. would take the time to develop the cases fully, it would save the Administration some money by eliminating the need to go to hearing.

In Jack Anderson's column of May 28, 1982, in the footnote, he mentions that Senator Jack Sasser is looking into reports that there are alleged quota systems. I want to assure the Committee that quotas do exist. In fact, it has been reported to me that if an examiner falls below the quota, he is given a letter of reprimand.

To show you how narrow D.D.S.'s focus is, if a case comes before the D.D.S. office on a psychological disability, even if documented evidence shows there are repeated attempts of suicide, this is not conclusive enough to grant disability status, according to D.D.S.

In addition, there is another problem that your Committee needs to address concurrently with the denial issue, and that is the exorbitant amount of time it takes Baltimore to issue checks. For example, I have one case in which a favorable decision was issued on December 9, 1981 and the Claimant has still not received any S.S.D.I. payments and/or his retroactive benefits. This type of situation is not unusual. It is a well known joke among those persons that deal with Social Security on a daily basis. It goes something like this... "Even Baltimore does not know what Baltimore is doing!"

In conclusion, I would offer the two cases below in synopsis for your perusal. Just a side note: on Case No. 1, unfortunately, the Claimant did not get to enjoy his Social Security because the day after he received his check, he died.

The second case I am submitting to you, because of the laborious process which he had to go through to get Social Security, he lost everything he had, including his car, his wife, his stepson and he still has not received his retroactive check from Baltimore.

Case No. 1

A 61-year-old while male (just under the age limit to draw retirement), very little formal education, he had been a brick layer and/or construction worker all of his life and paid into the system while he worked. He applied for Social Security benefits because of degenerative arthritis and severe back problems with associated pain. He was denied twice, came to me very distraught and could not understand -- why, after all these years of paying his dues that he couldn't get any help.

We took the case to hearing and won it on appeal but, even then, the process lasted approximately ten months. During that ten months he was on General Assistance which he had to pay back out of his retroactive benefits.

Case No. 2

This case involves a 34-year-old white male, armed service veteran, married with one step-child. He had a history of injuries and illnesses with arthritis as a result of injuries which manifests itself into severe pain, so much so that sometimes he cannot move for days. Also, he has to wear a TENS unit ( a mechanical device used for the blockage of pain impulses) constantly. He was a former painter, window-washer and hard-laborer type. Also, he had some mental manifestations because of the above symptomologies. He was denied Social Security which increased the mental anxiety to the point where it was having a very devastating effect on the physical ailments, and he had to be hospitalized several times during the course of the discovery period for the hearing. We were able to prove, despite the allegations by the State agency (Disability Determiantion Services) that the Claimant, because of his problems, could not work. The Court ruled that the Claimant was totally disabled.

Unfortunately, the story continues because at last report the Claimant, despite six months of waiting, still has not seen a check other than the one I was able to coerce the District Office into issuing.

Thank you for your kind consideration. If there are any questions please feel free to call on me.

Very respectfully yours,

Robert W. Ryan, S.W.

RWR:ms
Copies to Senator Carl Levin

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June 22, 1982

TESTIMONY FOR THE UNITED STATES SENATE

COMMITTEE ON GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

The Legal Services Corporation of Iowa wishes to thank Senator William S. Cohen and Senator Carl Levin for the invitation to submit written testimony regarding the Social Security Administration's (S.S.A.) current disability review process and its effects on disabled persons in Iowa. As a statewide legal services organization, our staff have been involved in representing several disability claimants in connection with the Continuing Disability Investigation (C.D.I.) process. During our most recent case reporting period (January 1982 through March 1982), Social Security/S.S.I. disability cases combined constituted the largest portion of LSCI's litigation caseload. Furthermore, the Social Security Administration has released statistics indicating that for the period of May 1, 1981 to February 26, 1982, 532 persons have had their benefits terminated in Iowa as the result of the C.D.I. process. Because of the referral relationship our program has with the Iowa Office of Hearings and Appeals, S.S.A., a sizable number of these individuals have sought representation from our program.

As you have requested, we are providing you with the following case studies of persons who have been selected and pro-

LSCI BRANCH OFFICES

cessed through the C.D.I. system. These case studies are being presented, not because they are in any way unique, but because they are typical examples of cases our staff have worked on in connection with the disability cessation process.

The claimants whose case studies we have included are not identified by name, but all have indicated to our staff that they would be more than willing to share their experiences with anyone interested in their stories. If any member of the subcommittee is interested in further discussions with any of these individuals, our program would be more than willing to make the necessary arrangements.

## Case Study #1

The claimant is a 45-year-old man who is a resident of Waterloo, Iowa. He has completed eighth grade and has worked as a cook and dishwasher for a period of 12 years prior to the onset of his disability.

He originally applied for Social Security and S.S.I. disability in December 1973, and was determined by the S.S.A. to be disabled with an onset date of September 30, 1973. He had received disability benefits continuously until S.S.A. determined in September 1981, that he no longer met the disability requirements. Upon receiving his notification of cessation of benefits, the claimant filed a request for hearing. He appeared before an administrative law judge of the Social Security Administration in January 1982, and was represented by the Waterloo Regional Office of the Legal Services Corporation of Iowa.

The claimant's medical history reveals that he was found disabled because of vitreous hemorrhages in each eye as the result of diabetic neuropathy, early senile cataracts, diabetes mellitus, and hypertension, being of such severity as to meet the S.S.A.'s Listing of Impairments (20 C.F.R. 404 Appendix 1, Part A). The S.S.A. determined that the claimant's disabilities had ceased to be disabling to the extent required, despite continued hypertension, cardiovascular disease, obesity, diabetes mellitus, and diabetic retinopathy.

The claimant underwent a consultative examination at the request of the S.S.A. in September 1981. This examination confirmed that the claimant continued to suffer from hypertension with hypertensive cardiovascular disease and congestive heart failure. The examining physician also noted the hemorrhages and cataracts in the claimant's eyes. The visual acuity in the right eye was approximately 20/200 and could not be improved, while the visual acuity in the left eye was worse than 20/200.

An ophthalmologist who examined the claimant wrote the S.S.A. stating that he felt the claimant was exaggerating his visual loss, but that he was still under a disability. This doctor observed the claimant point out a car in the parking lot during examination and concluded that this would be impossible if the claimant suffered the vision loss alleged. On the basis of this finding, the S.S.A. concluded in a notice to the claimant dated October 16, 1981:

> You were originally found unable to work because of your diabetes, high blood pressure, and eye problems. Your claim has recently been reevaluated. Medical evidence shows that you do have

> diabetes and high blood pressure, but no evidence of severe vital organ damage to be present. You do have some visual problems, but your vision is felt to be adequate. Based on the job you performed for the past twelve years as a cook, we have concluded that you have the ability to return to this job.

The claimant testified at his hearing before the S.S.A. that he had only told one of the workers in the doctor's office that a friend was waiting in a car in the parking lot, and that he did not point out a specific car. He stated he could not see the parking lot, much less any car in particular.

Following the claimant's hearing on his cessation, the administrative law judge found that he was under a continuing disability. Further, he held that the claimant continued to suffer from hypertension, cardiovascular disease, obesity, diabetes mellitus, and diabetic retinopathy, which had caused the loss of vision to a substantial degree in both eyes. The judge held that the claimant's loss of vision met the impairment described in the Listing of Impairments, 20 C.F.R. 404 Appendix 1, Part A.

In summary, this is a case where the claimant was allowed benefits for a wide range of disabilities, all of which were substantiated by medical evidence available to the S.S.A. Unfortunately for the claimant, a passing comment made during a consultative examination raised questions in the minds of some with the S.S.A. about the severity of his vision loss.

Obviously, the claimant was in poor health. His condition was exacerbated by the notice of cessation. Following the receipt of this notice, he became so nervous that he was unable to eat and the hair on his head began falling out. He stated that he felt that his family, who were financially unable to support him, were treating him like a stranger. His nervous condition and poor appetite elevated his blood pressure to a degree that caused his treating physician to double the dosage of his blood pressure medications, as well as his diabetes medication.

## Case Study #2

The claimant is a 47-year-old man who currently resides in a county institution in a northern Iowa county. He has completed eighth grade, with no other special training, and has worked as a delivery truck driver, taxi driver, road construction worker, and as a general laborer in a motor garage. He is residing in the county institution under court-ordered commitment.

The claimant was first awarded Social Security disability benefits with an onset date of September 15, 1974. He received benefits continuously until August 1981. In May 1981, the S.S.A. selected his case for a C.D.I. review and ordered a consultative examination. The resulting report was in direct conflict with the medical and psychiatric evidence contained in the claimant's medical file. On June 15, 1981, the S.S.A. sent him a cessation notice terminating his benefits retroactively to May 1981. He appealed his cessation of benefits and was represented by the South Central Iowa Regional Office of the Legal Services Corporation of Iowa.

At the time the claimant was originally awarded benefits, he was found to suffer from a chronic undifferentiated schizophrenic reaction. At that time he was suffering from hallucinations and marked inability to interact with others. Medical records established a severe impairment with hospitalizations dating back to 1963. He had been hospitalized several times, and had been admitted to a state mental hospital. His treating psychiatrist determined that the claimant's prognosis for recovery was poor.

Since he began receiving benefits, the claimant twice tried unsuccessfully to resume working. In each instance, these work attempts lasted only a few days. He had been hospitalized several times since receiving benefits, with the most recent hospitalizations occurring in 1979, 1980 and 1981. The claimant was committed to the county care facility in July 1981.

Commitment proceedings began in response to an episode in which the claimant had been drinking, threatening some children with violence and stating that he would bury them in his backyard. He continues to have frequent episodes of hallucinations and hostility, showing little insight into his condition or environment. He demonstrates an inability to control alcohol use unless in a well structured, supervised living situation, although he expresses the desire to get well and be released from the care facility.

Following the claimant's cessation hearing, an administrative law judge found that the claimant's condition was still severe enough to meet the Listing of Impairments related to functional psychotic disorders. He was reinstated for benefits and has been assigned a payee.

In its rationale statement, the S.S.A. based its cessation determination on the report of a consultative examination. No mention was made of any other evidence available in the claim file. The rationale relies heavily on the claimant's statements to the consulting psychiatrist denying hallucinations and alcohol use.

## Case Study #3

The claimant is a 33-year-old man who resides in Sioux City, Iowa. He has completed seventh grade, but cannot read and can only spell his name. He has worked at a variety of unskilled labor jobs, with friends and relatives finding him the jobs.

The claimant was first awarded Social Security disbility benefits in March 1975. He received benefits continuously until May 1981, when he received a notice from the S.S.A. stating that he was able to work. This notice included the following statement:

> Current psychiatric evaluation reveals that your attitude and behavior, at times, was mildly agitated but, for the most part, you were very cooperative and accessible. It is indicated that your stream of thought and speech were relevant and goal oriented. The exam revealed no evidence of any severe psychiatric problems at this time. You do not appear to have restriction in your daily activities nor constriction of interest. It is stated that you enjoy fishing and that you are able to go for coffee in a public restaurant each morning. Current neurological evaluation failed to reveal any significant abnormalities in regard to your back.

The claimant appealed the cessation of his disability benefits and appeared before an administrative law judge in April 1982. He was represented by the Northwest Iowa Regional Office of Legal Services Corporation of Iowa.

The claimant was originally awarded benefits because of severe emotional problems. These included chronic schizophrenic reactions, organic brain syndrome and depression. He also suffered from back problems that were the result of a work-related injury.

In May 1981, the claimant was examined by a consulting psychiatrist. In his report to the S.S.A., the consulting psychiatrist noted that the claimant would benefit from counseling in the area of personal hygiene. In addition, he found the claimant to be tearful, mildly agitated and suffering from speech and memory disorders. He stated that he believed that the claimant's judgment and insight were impaired. The psychiatrist diagnosed the claimant's disorder as being a functional non-psychotic disorder, manifested by seclusiveness, inappropriate suspiciousness, constriction of interest, deterioration in personal habits, and a seriously impaired ability to relate. The psychiatrist recommended that disability payments continue with the claimant's wife as payee, as he did not believe the claimant was capable of managing his own benefits. The claimant was also seen by a consulting neurologist in May 1981, who concluded that the claimant's physical ailments were exacerbated by his emotional problems.

Following the claimant's hearing, the administrative law judge held in his favor, finding that his disorders prevented him from engaging in continuous employment. The judge found that the claimant might have been able to work for short periods of time, but that his emotional and physical problems would cause him to quit or be terminated, as had happened on several occasions in the past.

When the claimant received his final disability check after his cessation, he attempted to work to support his family. He worked for a short period as a part-time custodian at a local restaurant. In addition, he received county relief assistance contingent upon working for the county. While working for the county, he reinjured his back and consequently lost his part-time custodian job. A week later he was in the hospital for a herniated disc, a condition resulting in surgery shortly thereafter. The county now faces payment for the surgery and there is a pending worker's compensation claim against the county.

The claimant's twelve months without disability benefits caused considerable emotional problems for him. The anxiety and depression from not being able to care for his family caused him to contemplate deserting his family so that they would be eligible for AFDC. Eventually, he considered suicide as a way to end his pain and his family's financial problems. Fortunately, however, the claimant's benefits were reinstated before any further irreversible damage was caused to himself and his family.

As stated previously, these three case studies are representative of the types of cases our program has been handling since the continuing disability investigation process was initiated. As representatives of people seeking and receiving Social Security and S.S.I. disability benefits, we would support the following changes in the continuing disability investigation process.

1. Elimination of the reconsideration level of the S.S.A. appeals process, with provisions for an immediate hearing before an administrative law judge. The reconsideration stage of the appeals process causes a delay in the decision making process which tends to be adverse to claimants. Few cases are reversed at the reconsideration stage and it is our experience that claimants are not afforded a thorough independent review of their cases until they appear before the administrative law judge. We believe that by eliminating the reconsideration level, claimants will be provided a more rapid review of their cases and a review that will more closely consider their actual condition. It is essential that each claimant have an opportunity to present evidence and testimony in person to an impartial decision maker. It is impossible to make a fair assessment of a claimant's physical and mental impairments without the opportunity to visually observe the claimant and ask him/her questions. The reconsideration level, as it currently exists, does not allow for this type of review.

In addition, ALJs are required to consider not only Social Security statutes and regulations, but also appellate court decisions establishing interpretation and precedent in relation to these statutes and regulations. The state agencies that conduct reconsideration determinations do not consider legal precedent and, as a result, are often reversed by the ALJs. An example of a common practice of state agencies, that results in their being reversed later in the appeals process, involves the weight given the reports of consultative examiners, as compared to reports provided by a claimant's treating physician. State agencies nearly always give more evidentiary weight to consultative exams, as compared to the medical reports provided by treating physicians. This practice has generally been found to be illegal by various appellate courts and, as a result, creates a situation where state agencies are frequently reversed by the ALJs and the courts. We see little value in continuing a process that ignores the precedents established by our judicial system. Therefore, contrary to the proposals we have seen presented so far in Congress, we support the continuation of the appeal hearing process, with the reconsideration level being eliminated.

2. Disability benefits should be continued to claimants undergoing the continuing disability investigation process during the period they are appealing their cessation of benefits. The continuing disability investigation process and subsequent appeals process often force claimants to survive several months without continued payment of benefits. Many of these claimants, because they have lived on fixed incomes, have little or no savings upon which to depend during the appeals process. Since the claimant's dependents also lose all benefits at the same time as the claimant, many of these families are forced onto the welfare rolls.

For the disabled individual not eligible for AFDC, the only alternative for survival may be to receive food stamps and some type of local relief, if such relief is available. Not only do many of these individuals live on little or no income, but many are forced to forego needed medical care. We believe that benefits should be continued during the administrative appeals process.

3. The quality and use of consultative examinations by state agencies should be reviewed. It is not uncommon for many of our clients to have complaints regarding the consultative examinations they have undergone at the direction of the state disability evaluation agency. One complaint is that the exams are often superficial and last only a few minutes. Apparently, it is common for claimants not to be given certain basic tests, such as range of motion or tandem walking tests. Finally, our program has heard complaints from some claimants regarding the way in which they are treated by the consulting physician. One health care provider requires claimants dressed in hospital gowns to go from one building outside to another, in order to receive x-rays and other tests. This practice is followed even during winter months.

It has also been the experience of some of our staff that the state agency gives more weight to the consultative examiner, as compared to the treating physician. In addition, some of our staff have observed that claimants have been sent to more than one consultative examiner, if the first has rendered a medical judgment favorable to the claimant.

It is imperative that the quality of the consultative examination be improved. Not only should more specific medical information be required, but the examination itself should be more thorough and humane. Finally, these examinations should be considered in view of the reports of the treating physician, as opposed to being used as a substitute for such evidence.

We generally agree that there is a need for some form of periodic review of the conditions of persons receiving disability benefits. However, it has been our experience that the current method of conducting these reviews has resulted in a great many truly disabled persons being terminated from the program. We cannot overstate the trauma that these cessations have caused many of our clients.

The major flaw in the current continuing disability investigation process appears to be caused by the state disability evaluation agency's failure to fully consider, in an objective fashion, a claimant's disabilities. The behavior of the state agency often appears to be motivated by a desire to terminate people from the program, as opposed to objectively reviewing their continued eligibility for benefits.

We hope that the Subcommittee will consider the suffering being caused by the current system and respond in a fashion that not only maintains the integrity of the Social Security disability program, but also is equitable to disabled persons.

We thank you again for the invitation to submit written testimony in regard to this important issue.

Respectfully submitted,

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Statement Submitted for the Hearing Record from a former Social Security Administration employee. To comply with his request for anonymity, the Subcommittee has deleted all references to his name and the city and state of his former employment.

## Introduction

Mr. Chairman Cohen and members of the Subcommittee, I am a former employee of the Social Security Administration and currently a law student at University. Prior to March 1982, I worked for SSA for seven years in a variety of claims handling and management positions. Most recently from July 1981-March 1982, I worked for the Assistant Regional Commissioner for Field Operations in and was directly involved with the Continuing Disability Investigation process. My testimony is based on my observations during that period.

I thank you, Mr. Chairman and members of the subcommittee for the opportunity to present my views on the CDI process.

Almost everyone will agree that a process of continuing disability investigations is necessary to insure that disability benefits are paid accurately to individuals who truly deserve them. Because of the immense work load in the mid and late 1970's the Administration clearly recognized that there were a large group of disabled recipients who no longer met the standards of eligibility. Some studies estimated that the ineligibility rate was as high as 18% to 20%.

The Bellmon amendment was a well intended attempt to refocus the Administration's attention on this workload.

However, the current overwhelming and ill-timed emphasis on this workload has distorted the true objectives of the program. As I will discuss below the disability determination staffs have been given unattainable goals and inadequate staffing. The current Administration believes that the number of ineligible beneficiaries is much higher than the past Administration had predicted. In essence this is a self fulfilling prophecy for by accelerating the workload goals and by failing to provide adequate staffing, the disability determination staffs have no alternative but to dramatically increase their cessation rate. The cessation rate is not higher because there are more frauds and cheats, but simply because the Administration is doing a haphazard and reckless job of conducting these reviews.

## Summary

### Workload

- The current workload goals are unreasonable and unattainable.
- Because of the unreasonable workload goals quality and due process suffer.
- SSA's emphasis on processing time rather than quality encourages cessations and creates de facto cessation goals.

### Quality

- Current quality reviews are inadequate and self serving because of limited resources and the limited scope of their review.

- By focusing quality reviews on continuances, SSA encourages cessations.

Due Process - Appeals

- Beneficiaries are denied adequate notice and are misled as to the scope of the CDI review.

- Appeals process delays amount to 12-18 months before benefits are reinstated.

- Current ALJ goals to reduce their reversal rate will make it increasingly difficult to handle this workload

Workload

As you know SSA dramatically accelerated the workload goals under the Bellmon amendment. In fiscal year 1982 the Administration plans to complete 567,000 CDI's, of which 58,000 are in the region and 28,000 are in . The Administration has clearly communicated this goal to the state agencies and aggressively monitors their completion of this workload. However, the State agencies lack the resources to effectively complete this workload.

In each state the workload of continuing disability investigations has increased dramatically without a concomitant increase in staffing. For example, in 1980 the disability determination staff completed around 40 to 50 CDI's per week. In 1981, SSA permitted the DDS to hire an additional 40 examiners. However, these examiners could not handle CDI's until their six month probation period was completed. Including the new examiners, the DDS completed around 100 CDI's per week in 1981. In fiscal year 1982, the DDS is required to complete about 28,000 continuing disability investigations or in other words an average of over 500 a week. As of March 1982, the DDS was over 5,000 cases behind this goal and the Regional office was placing tremendous pressure on them to develop these cases as quickly as possible.[1]

It cannot be sufficiently emphasized that these overwhelming workload goals have a direct and adverse effect on the quality of the determinations being made. First, DDS examiners find that they have to complete four or five times as many cases in the same amount of time. There is simply not adequate time to properly develop the existence of an individual's impairment.

Since state agencies are also evaluated on CDI processing time there is an added incentive to cease cases. Continuances take 30-45 additional days to process. Moreover, the manner in which cases are developed make it easier to terminate rather than continue benefits. Disability examiners have been instructed to focus on one impairment rather than investigate all potential impairments. If the disabled individual is found ineligible based on cessation of that one impairment the examiners are instructed not to investigate other possible impairments which might make the person disabled. Many individuals are being terminated on impairments which were not even the basis for their being awarded benefits, while far more severe impairments go undeveloped.

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[1] It is notable that the Regional Office focused their efforts on production rather than quality, since at that time the cessation rate (60%) was much higher than the Regional cessation rate (40-50%). Yet SSA focused only on the production quotas, rather than questioning high cessation rate. (see attachment 1).

The size of a state agency's workload has a direct adverse impact on their cessation rate. In the region, those states with the greatest backlog had the highest cessation rate. Workload pressures have a direct and clear impact on the size of a state's cessation rate. Yet SSA makes no effort to relieve those heavily backlogged Stated or reduce their workload goals.

Finally, the overwhelming emphasis on workload processing deprives adequate manpower for a quality review. Because the workload goals are ultimate, quality reviews of CDI's are infrequent and cursory.

CDI Quality

The Administration's contention that CDI's have a high accuracy rate is misleading and inaccurate. In their testimony SSA contends that the current CDI accuracy is a remarkable 97.5%. SSA also stated that up to 40-45% of current disability recipients are ineligible. These are very intriguing comments. On the one hand, they contend, that the prior disability determinations were made so poorly that over 40% of the currently eligible recipients are being paid erroneously; on the other hand current disability determinations have improved so dramatically that the disability determination staffs have a near perfect record in conducting CDI's. It is unreasonable to assume that the disability staffs have reversed their poor quality and found perfection in such a short period of time.

As a former assistant to the Director of the Region Quality Assurance staff, I want to emphasize that these statistics can be manipulated and must be taken with a very large grain of salt, for the following reasons:

1. Social Security internal reviews of their disability process have consistently shown that they had high quality in initial determinations and CDI's. Yet, as you know, a great portion of initial claims have consistently been reversed at the ALJ level. This is because the scope of the review being conducted is extremely limited. SSA simply reviews the file to determine whether there was sufficient evidence, or lack thereof, to establish that the recognized impairment has ceased. The review does not attempt to determine whether or not there was some other type of impairment which was not properly documented. Nor does the review

attempt to recontact the individual to determine whether or not the case was properly developed.

2. The cases upon which these statistics are based were pre-reviewed by the State Agencies before the SSA review. Thus, the folders were cleansed of any unsightly errors.

3. Until recently the review, had simply focused on CDI continuances. For example, in fiscal year 1982 the Administration's goal was to conduct a review of 35% of the CDI continuances. Until April of 1982 no review was conducted of the termination cases; therefore there was no data being gathered on the accuracy of the termination cases.

As of April 1982 the region began to conduct a review of cessation. However, no formal feedback mechanism has been established and because of extreme time and manpower limitations few, if any, states are conducting a 100% review of cessations.

The importance of focusing the review on continuances rather than terminations cannot be underestimated. I know from my personal experience that if an examiner recognizes that a certain type of case is going to be reviewed the examiner will naturally try to avoid having those cases or will provide more thorough documentation. If given a choice, an examiner will more likely deny or discontinue a case, knowing that these cases are much more likely not to undergo a second review upon which an error can be detected. Therefore, both the tremendous workload demands that are being placed on the DDSs in the manner of the secondary review provide tremendous incentives for examiners to terminate cases.

## Cessation Quotas

From my experience, SSA diligently and consciously avoids establishing or even referring to cessation minimum or maximum goals. Obviously the Administration has good reason to avoid putting these goals into writing. However, de facto quotas do exist and are enforced. These quotas come about from the interaction of the following factors. First, of all there are definitely workload goals upon which the Administration places a tremendous emphasis. Because of the emphasis placed upon these workload and processing time goals there is a strong incentive for States to increase their cessation rate, since cessations take less time to process than continuances. Second, it is easier to document a cessation than a continuance, and cessations are not reviewed.

Third, SSA seems intent on selecting disability examiners who have an anti-beneficiary inclination. In

Massachuusetts, potential examiners are asked whether they believe disability benefits are a "legal and moral right" or that a disability recipient should "pull their own weight" (see attachment 3). These questions seem a clear attempt to select those examiners who would be more likely to terminate and less sensitive to the needs of the disabled. The message to the current examiners, is "terminate or else!"

Finally, and perhaps most important, in evaluating the performance of the DDS's, SSA focuses their attention on those states which have low rather than high cessation rates. There are various ways to analyze the performance of each of the states. In the region, it was common practice to focus on those states with a low cessation rate and inquire why their cessation rate was so low rather than focusing on a state with a high cessation rate and inquiring why their cessation rate was so high. In that way states with the high cessation rate became the norm and the implication arose that all states must comply with that norm. For example, the cessation rate is clearly higher than any other state in the Region. SSA's focus has not been on abnormally high cessation rate but rather on those states with cessation rates below the average. In that way all states are encouraged to have as high a cessation rate as possible and since little analysis is done of the true accuracy of the cessation there is very little reason for the Administration to believe that a high cessation rate is not proper.

Due Process - Appeals Process

With the acceleration of the CDI workload, State Agencies were just not capable of providing adequate due process to the beneficiaries whose cases were being reviewed. The States possessed neither the manpower nor the computer systems capability to provide adequate or meaningful notice. Because of the lack of systems capability, many beneficiaries do not receive timely or adequate cessation notices, and only learn of their termination after their checks fail to arrive. Not only do these individuals suffer substantial hardships, but this is a denial of any meaningfull due process.

Moreover, the intitial notice, if sent, does not provide an adequate explanation of the CDI review. In the Region, we permitted the State Agencies to skip the initial notice and simply contact the beneficiary by phone. This certainly is not adequate due process. The initial notice itself is full of bureaucratic language and lacks a clear statement of:

- the purpose of the CDI;
- what information must be provided;
- that the beneficiary bears the burden of proving their eligibility (as in an initial claim);
- where the beneficiary can receive assistance.

The forms provided for the beneficiary to complete are complex and lengthy. In all too many cases, the beneficiary, believing this is a "review" and not a "reestablishment of eligibility", submits a brief letter from their physician indicating that their impairment continues. Since the physicians letter contains little hard evidence (because the physician does not recognize that additional evidence is necessary) it is ignored by the State Agency. Neither the beneficiary nor the physician ever know what evidence is necessary to reestablish eligibility.

According to SSA's own estimates approximately 60-67% of terminations will be reversed at the ALJ level. Yet this is inadequate and untimely relief. First, not all terminated beneficiaries file for a hearing. Many individuals simply give up believing that the appeals process offers no hope of relief. Second, those who appeal must wait 8-12 months until a hearing is scheduled. Third, after receiving a favorable reversal by the ALJ, beneficiaries must wait 3-5 months until their benefits are reinstated. It is disheartening that with this high reversal rate, SSA has made no effort to expedite the appeals proccess or the reinstatement of benefits after a favorable reversal is received. Certainly, such an expedited appeals process could be established.

Moreover, SSA's goals to reduce ALJ processing time and their reversal rate will adversely affect the ability of the

ALJ's to handle this workload. As terminations increase, the ALJ workload will increase without a concomitant increase in staffing. Their goals to reduce their reversal rate (4% in FY 1982 and an additional 6% in FY 1983) and processing time will make it increasingly difficult for them to reverse these cases or handle this workload on a timely basis .

Recommendations

All of us recognize that a disability program which pays benefits to such a large number of individuals needs some type of continuing disability investigation process to assure those benefits are paid accurately. But such a process should recognize the limitations of administrative resources and the human dimensions of the potential problems that can be brought from improper terminations. This Administration does neither. It attempts to complete a clearly unreasonable workload with inadequate manpower and insufficient time. Moreover, the manner of completing the workload shows its rank insensitivity to the needs of the disabled individuals affected by these reviews. My recommendations for improvement of this process are as follow:

- Workload and processing time goals must be delayed or eliminated. SSA's performance should be evaluated primarily on accuracy rather than processing time.

- An independent and accurate quality appraisal merchanism must be established. A 100% pre-cessation review should be implemented.
- SSA should focus on those states with high cessation rates to determine the accuracy of their determinations.
- Title 2 disability benefits should be continued through the appeals process.
- The initial notice should clearly indicate the scope of the CDI review and what information is necessary to reestablish eligibility.
- SSA should create an expedited appeals process.
- Face to face interviews should be conducted prior to any cessation.

Workload and Quality

First, SSA must reduce or temporarily delay their CDI workload goals. The current goal of completing over 567,000 CDIs in a year is unreasonable. Faced with these goals the States have no alternative but to perform a haphazard and slipshod evaluation. The administration must refocus their goal to one of quality rather than quantity. Considering the amount of human hardship involved and the current 67% reversal rate, quality must be the primary objective in completing this workload.

In terms of improving quality, SSA must refocus their review efforts on cessations rather than continuances. As indicated earlier, it is much easier to document a cessation than document a continuance. Yet SSA seems to have consciously avoided reviewing cessation cases. The administration must implement a 100% pre-cessation review by another doctor and examiner before the benefits can be ceased. This review should be thorough, documented and Congress should require the Administration to report on the results of the review on a monthly basis.

Moreover, Congress must implement their own studies to determine the accuracy of the reviews being conducted by the Administration. I know from my own experience that accuracy figures are easily distorted and often inaccurate. Congress must critically evaluate data presented by SSA. Moreover, Congress should implement their own study to evaluate the accuracy of the CDI process. It is crucial that these studies go beyond a simple folder review to determine whether or not the Administration has fully developed all and any potential impairments.

### Due Process and Appeals Process

First, from a human perspective, a great deal of hardship could be alleviated simply by continuing title 2 disability benefits until the appeals process is completed. As noted earlier, terminated beneficiaries will wait from 12-17 months until their benefits are reinstated by an ALJ. The amount of human hardship that occurs during this interim period cannot be understated. Currently, SSI benefits are continued until the appeals process is completed and SSA has no difficulty recouping these benefits in those cases where the termination is affirmed by the ALJ.

The initial notice sent to the beneficiary must clearly indicate that the CDI is not a review, but rather a reestablishment of eligibility, and the beneficiary bears the burden of reestablishing their eligibility for benefits. The notice must clearly indicate what information is necesary. Rather than having the beneficiary complete the CDI form, the examiner should contact the beneficiary and complete the form either in person or on the phone. It is notable that in an initial claim, the disability interview form must be completed by an SSA employee. Since a CDI is a reestablishment of eligibility, it is reasonable to extend this requirement to the CDI process.

Finally, prior to cessation, SSA should conduct a face to face interview with the beneficiary and provide them 30 days (instead of the current 10 day limit) to provide any additional information. In this way, the beneficiary will be afforded a more extensive opportunity to document their continuing eligibility. Moreover, a cessation reversed at this level will avoid a long and costly appeals process.

## Conclusion

Mr. Chairman, and members of the Subcommittee, I appreciate the opportunity to present this testimony. This is a critical issue which demands the prompt attention of Congress. I hope it continues to receive that attention.

LIMBERIS & MACDONALD
ATTORNEYS AT LAW
30 COLUMBIA STREET
BANGOR, MAINE 04401

GEORGE P. LIMBERIS
WILLIAM E. MACDONALD
CHRISTOPHER G. LIMBERIS

June 18, 1982

Senator William Cohen
Attn: Susan Collins
1251 Dirksen Senate Building
United States Senate
Washington, D.C. 20510

Dear Senator Cohen:

I would like to take this opportunity to comment on the Continuing Disability Investigation Program which is currently being conducted by the Social Security Administration nationwide. By way of background, let me state that I am currently employed as a Paralegal with the law firm of Limberis & Macdonald here in Bangor. My work is almost exclusively with Social Security Disability cases. Prior to my employment here last October, I spent some seven years with Pine Tree Legal Assistance in Bangor, again, working almost exclusively on Social Security cases.

While it would be sufficient for me to state that the current Continuing Disability Investigation Program is perhaps the worst injustice perpetrated upon Social Security recipients in the years that I have worked with the program, I would like to go further and cite some examples of cases which have recently come through this office.

The first is a case of a gentleman we will call James Dole (not his real name). Mr. Dole had been receiving Social Security Disability Benefits since 1979 for cardiac and severe neurological impairment. In layman's terms the nerves in his upper extremities were dying and he needed to undergo a number of surgical procedures but has still not the use of those upper extremities. On January 3, 1982, Mr. Dole went to his mail box to obtain his monthly Social Security check but did not receive it. on January 22, 1982, he finally received a written notice that the Administration was terminating his benefits and that he had received his last check. Since that time, Mr. Dole finally got before an administrative law judge who has, at this writing, unofficially indicated that Mr. Dole's benefits will be restored. This indication comes about as the result of two medical advisors (medical doctors) to the Social Security Administration indication that Mr. Dole has and continues to meet the secretary's listing of impairments. Unfortunately for Mr. Dole, in the interim to go through a bankruptcy procedure which resulted in the loss of his house, land and all that his family had worked for during the 58 years of his life. While it is true that Mr. Dole's benefits will not be restored, it is also true that the three or four thousand dollars in back benefits can not possibly allow him to recover what he has lost as a result of this action by the Social Security Administration. One might also add that Mr. Dole has a truly illustrious war record with the Royal Canadian Navy, for which he volunteered, during World War II. He was involved in the bringing to action and destruction of numerous major German warships including the Tirbitz, sistership to the infamous Bismarck.

Next, let me cite the story of Elmer Beale (not his real name). Mr. Beale was a recipient of Social Security Disability Benefits for some 10 years before being advised in September of 1981 that his benefits were being terminated. Mr. Beale originally went on the Social Security program after a large peice of metal broke loose from the tractor-trailer auto transport he was driving and crushed neck and cervical bones in his body. Mr. Beale promptly requested a reconsideration of the administration's decision and the administration justice promptly lost his file. Of course, it took some three months before a reconsidered determination was issued by the Social Security Administration. During this period of time, I might add, the claimant has been confined to a wheel chair prescribed by his treating orthopedic physician who is located in Camden, Maine. As a result of the difficulties, the claimant encountered with the Social Security Administration, he also developed endogenous depression, cronic and severe. As of this writing, I have been informed unofficially by the administrative law judge, that it is his intention to issue a favorable decision restoring Mr. Beale to the Social Security Disability roles. Also, as of this writing, however, Mr. Beale's depression has deepened to a point where he verges on being suicidal. His phone has been disconnected and he is constantly hounded by bill collectors. He lives daily in fear of the loss of his home and possessions that he and his wife have worked for throughout their adult lives.

I point to these two examples of the effect of the Continuing Disability Investigation Program because they are cases which are being monitored by your Bangor staff. Thus, they are known and easily verifiable. Obviously, I would be happy to provide the real names of the claimants if you desire them and the claimant's are willing to release this information.

The unfortunate part of this is that these two gentleman are not atypical or isolated examples of a program that is otherwise functioning smoothly. This program is a clear, present and unmitigated disaster to thousands of Social Security recipients throughout the country. It is being administered by what apparently are people totally devoid of compassion and understanding. I say this because the vast majority of these cases are decided favorable by administrative law judges and their medical doctors advisors based on much the same evidence that is available to the State agencies when they cease disability. In so many of these cases, it is so manifestly clear that the claimant continues to be disabled that I have often heard expressions of disgust from professionals such as medical doctors, psychologists, and vocational specialists who become involved with the case at the hearing level.

I would also like to add that from March of 1979 to March of 1982 I served on the Board of Selectman for the Town of Franklin in Hancock County. Even in that position, in such a small town, I noticed in the last six months of my term the beginnings of the impact of this program on citizens of the town.

My recommendations would be that this program be ceased immediately if not sooner. Barring it cessation, I would strongly recommend that the Congress consider uniform ajudication standards that are similar to those used by the administrative law judges than the program operations manual system (poms) which is currently being proposed by the Social Security Administration. The poms is so complex and complicated that when I requested my copy of it, it arrived in a large box to hold the entire manual. Surely, the implementation of this system at the hearing level could only further complicate and confuse an already disasterous situation.

I would be happy to provide whatever additional information you may desire.

With best wishes, I am . . .

Sincerely yours,

Henry B. Obermann

Henry B. Obermann

HBO/emh

# STATEMENT OF
# CHESTER SHATZ, ADMINISTRATIVE LAW JUDGE
# AND
# NEW ENGLAND DIRECTOR OF THE ASSOCIATION OF ALJS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Committee, I appreciate the opportunity to appear here today to discuss some of the administrative law judges' concerns related to the continuing disability review process being performed by the Social Security Administration. By way of introduction, I am an administrative law judge stationed at Boston, Massachusetts in the Office of Hearings and Appeals of the Social Security Administration. I am one of 10 Directors of the National Association of Administrative Law Judges of the Department of Health and Human Services, and I am appearing here as the representative of the Association.

First let me say that the large volume of continuing disability reviews being performed by the Social Security Administration results from a Congressional mandate requiring such reviews. Thus our Association has no quarrel with the continuing review of cases in which individuals have been previously found disabled. However, what we have seen in cessation cases coming to the hearing level is that the reviews performed at the state agency level have been done too swiftly, and we also note that standards used for determining disability at the state agency level are different from the standards prescribed by the Social Security Act and the Secretary's published Regulations.

With regard to the speed in which such review of termination cases are performed, we have found in a vast majority of the cases that there has been poor development of the medical record at the state agency level. In all fairness to the state agencies, we believe that such poor development is due in great part to an extremely large state agency workload, understaffing of the state agencies, and arbitrary time constraints imposed on the state agencies for processing cases. Nonetheless, the cold hard fact remains that the medical evidence upon which the state agencies decide to terminate a disabled person's benefits is usually incomplete and non-current. The Administrative Law Judges often feel that the hearing level has become the "dumping ground" for the hurried state agency process. Of course, it is fundamental that it is not fair or just to cease benefits on an inadequate record. Under those circumstances the public is getting "short-changed". It is not a fair argument to make that when the case reaches the Administrative Law Judge level, proper development of the evidence can be made. The difficulty with that argument is that many claimants, who have been terminated at the state agency level become discouraged and oftentimes incorrectly feel that it would be useless to appeal to the hearing level. It must be remembered that many of the disabled who are unjustly terminated from benefit status are people who are aged and who have limited educations. Thus, many of these persons lack the sophistication necessary to fully understand their appeal rights. Thus, many individuals who have worthy cases lose benefits because of improper review by the state agencies. With regard to those who choose to appeal to the hearing level, our experience has indicated that the majority are found to be disabled at the Administrative Law Judge level. We therefore are of the view that the review process at the state agency level needs to be dramatically upgraded so that worthy cases do not fall by the wayside.

Aside from the above, we point out that we believe that the state agencies cease benefits because of (1) apparent fear of being criticized for faulty reviews and also (2) because of being directed to follow standards that are inconsistent with the Social Security Act and the Secretary's published Regulations (which have the full force and effect of law). With regard to pressure exerted on the state agencies, we have no information whether direct pressure is being applied. However, we do believe that the method of Social Security Administration review of their favorable decisions exerts an indirect pressure on state agencies to deny and/or cease benefits. In this regard, it is important to note that the state agencies are informed that (1) review by the Social Security Administration will be made in a large percentage of cases where the state agency finds that benefits should not cease, and that (2) only a very small percentage of the cases ceased will be reviewed. This review practice has been utilized for many years, and while not direct pressure, it can be argued it is subtle pressure exerted on the state agencies to terminate benefits or else be subject to possible criticism by the Social Security Administration. Moreover, we note that state agencies cease benefits in many cases without having any personal contact with the person being ceased. Thus, the extremely important decision to terminate benefits occurs from a mere "paper review" of the record compiled by the state agency. We think that prior to cessation of benefits, the stage agencies should be required to afford the person involved with an opportunity for a face-to-face interview.

With regard to the standards used by state agencies in determining whether or not a person is disabled, it is important to note that state agencies do not follow the disability standards of the Act or the Secretary's published regulations, both of which are binding on the public and Administrative Law Judges. Rather they are told to follow instructions that neither are published nor subject to rule-making under the Administrative Procedure Act, and which are often at variance with the standards set forth in the Social Security Act and the Secretary's published Regulations. In this regard, it is interesting to note certain points made by the Secretary of DHHS in his recent report to the Social Security Subcommittee of the House Ways and Means Committee, which he was required to furnish under Section 304(g) of P.L. 96-265 (Social Security Disability Amendments of 1980). From that report, it would be in order, at this point, to look at the rates of denial at the initial, reconsideration and judge levels for the 5-year period from 1975 through 1980. A review of this data shown on page 9 of the Secretary's Report indicates the following:

(1) Initial level - 1975 through 1980 went from 60% denials to 67% denials (See page 9 of Report)

(2) Reconsideration level - 1975 through 1980 went from 67% denials to 85% denials (See page 9 of Report)

(3) ALJ level - 1975 through 1980 went from 51% denials to 42% denials (See Page 9 of Report).

As can be seen from the above, as both the initial and reconsideration denials increased the ALJ denial rate decreased. Two reasons can be identified for such a decrease in ALJ denials. In the first place it seems clear from the Secretary's Report that the state agencies (DDS) began to apply extremely more stringent standards for determining "disability" than previously applied and stricter than the disability standards set forth in the Social Security Act. (See page 24 of Report). Although the statute had not changed with regard to definition of disability, the agency at the lower levels (i.e. initial and reconsideration stages) apparently found only those persons meeting the Listings set forth in the Regulations to be disabled (The Listings consist of those severe impairments which the Secretary has presumed mandate a finding of disability within the meaning of the Social Security Act without regard to consideration of vocational factors). Thus other individuals who did not have impairments meeting the Listings, but who nonetheless were "disabled" within the meaning of the Social Security Act, were denied benefits at the initial and reconsideration stages. Is it any wonder that requests for hearings and judge allowance rates increased substantially during the period from 1975 through 1980? That latter point is mentioned in the Secretary's Report on page 24 wherein he notes that because of a decrease in allowance rates at the lower levels, a reciprocal increase in ALJ allowance rates occurred.

Another reason for further increase in ALJ allowance rates from 1979 through the present was the introduction of the so-called "grid Regulations" in 1979. The most simple illustration of the problems associated with the new regulations is in the area of claimant's burden of proof. The DDS has, for whatever reason, probably unwittingly, used the new sequence, as it appears in the new regulations, to create a new, more strict test for the making of a prima facie case than has heretofore been understood by all levels since the 1967 amendment. The DDS, by using the Program Operations Manual (POMS), provided by the Office of Disability Operations, SSA, treats the burden of proof as follows:

> "When there is no significant limitation in the ability to perform these work-related functions, an impairment will not be considered to be severe even though it may prevent the individual

from doing a highly selective group of jobs, including work that the individual has done in the past.'

The judge, following the well-established burden of proof, as enunciated in the regulations and in all court cases, finds that the claimant has made a prima facie case when he cannot return to his former job. Put more simply, once the judge finds that a claimant has a "severe" impairment that keeps him from doing his former work, the burden of going forward with the evidence shifts to the Secretary.

The different interpretation taken by the State agency has permitted it to find claimants' impairments to be "not severe" even when they cannot return to their former work. In practice, the tendency seems to be to make a finding of "not severe" in most cases where a finding of "severe" would cause a payment of benefits by use of the "grid". The judge, on the other hand, is constrained to find that claimants, who cannot return to their former jobs and who fall into a certain "pigeon hole" in the grid, are "conclusively disabled".
If there is one single objective reason for the decline in the DDS rate in the last few years, we submit this reason.

Moreover, as pointed out on page 19 of the Secretary's Report, the DDS do not follow "ALJ practice" in finding residual functional capacity less than sedentary. The reference to judges finding residual functional capacity less than sedentary as being "ALJ practice" is a misnomer since the Secretary's published Regulations state that a finding can be made of residual functional capacity less than sedentary. It is the DDS that is in error here because they are ignoring the Secretary's published Regulations in that regard, probably because of erroneous guidelines imposed on them by either the Office of Assessment or Office of Disability Operations of the Social Security Administration. Another example of DDS failure to follow the Secretary's published Regulations, as pointed out on page 19 of the Report, is the failure to recognize pain (resulting from a significant impairment) as being a disabling impairment. Such failure on the part of DDS ignores not only the Secretary's published Regulations, but also all Court precedents holding that pain produced from a significant impairment must be considered in determining whether or not a person is "disabled."

A third example of DDS failure to follow the Secretary's published Regulations is pointed out on page 19 of the Secretary's Report wherein it is noted that DDS do not consider the combined effect of a nonsevere mental impairment and significant physical impairments in assessing whether a person is "disabled" despite the Act and the Regulations requiring such consideration. Finally, we note that the state agencies ignore the conclusions of their own consulting doctors. Very often we find that such reports indicate by way of opinion that a claimant is unable to work. Despite those assessments, the state agencies rely primarily on the opinions of its own staff doctors who never see the claimant but merely conduct a "paper review" of the record. Their assessment is treated with great reverence and considered superior to the assessments made by the impartial physician who has had a face-to-face contact with the claimant and who has performed an actual examination. Thus, the better evidence is totally ignored and instead hearsay opinion is given great weight.

With regard to pressures being exerted on administrative law judges to deny cases, we can not point to any direct pressure being applied. However, we have noted that certain comments have been made by the non-judge personnel within the Social Security Administration that our allowance rates may be too high. Moreover, the Social Security Administration has implemented a program of reviewing all decisions of administrative law judges who have so-called high allowance rates. No such program has been implemented with regard to those judges who have high denial rates. Thus, one can reasonably conclude that the implementation of a review program aimed at only those who have above average allowance rates is the exercise of subtle pressure toward effecting a lower allowance rate of the judges.

In concluding we offer the following recommendations:

(1) Strengthen the state agency review process by making it mandatory that they follow the disability standards set forth in the Social Security Act and the Secretary's published Regulations and not those included in secret, unpublished guidelines which are often at variance with the Act and Regulations.

(2) Separate the Office of Hearings and Appeals from the Social Security Administration by establishing it as a Social Security Review Commission. We believe that if the Office of Hearings and Appeals had such independent status, the Social Security Administration would more readily instruct the state agencies to determine disability in accordance with the definition of disability as contemplated by the Social Security Act.

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**IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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**PAST PRESIDENT**

FRANCIS J. O'BYRNE
Chicago IL., S 8-886-5538

June 2, 1982

Ms. Barbara Savage, Minority Counsel
Senate Subcommittee on Oversight
Room 3306
Dirksen Senate Office Building
Washington, D.C.

Dear Ms. Savage:

I was present at the hearing held on Tuesday, May 25, 1982, concerning continuing disability reviews by the Social Security Administration, and it was my understanding that the record would be kept open for further written comments until June 25, 1982. Thus, this letter is being written for that purpose of inclusion in the record, and my comments herein pertain to certain testimony elicited at the hearing. By way of introduction I am an administrative law judge attached to the Social Security Administration, and I am the New England Director of the Association of Administrative Law Judges of the Department of Health and Human Services.

My first comment relates to the testimony of the Social Security Administration officials concerning the Administration's policy of issuing directives not to follow certain decisions of the Circuit Court of Appeals. As I understood the testimony of the Social Security officials, it was the Administration's position that the policy of non-acquiescing in some of the decisions rendered by the various Circuit Courts of Appeals was based on the theory that the Social Security program was a "national program." While that fact may be so, it is clear that under our system of government, the Courts have the "last word" concerning interpretations of a statute. It would be ridiculous to argue that the Social Security Administration would not be obligated to follow a U.S. Supreme Court holding despite the fact that Social Security is a "national program." It would seem to us that the same argument would apply for the geographic area over which a Circuit Court of Appeals has jurisdiction when the Social Security Administration fails to appeal the Circuit Court's decision (or if it does, when a writ of certiorari has been denied by the Supreme Court). In this regard, it is important to note the holding in Allegheny General Hospital v. NLRB, 608 Fed 2nd 965, at 970 (1974) wherein the Court pointed out that a decision of the Circuit Court of Appeals, not overruled by the U.S. Supreme Court, is a decision of the Court of last resort in that particular federal judicial circuit and is binding on administrative agencies. The Court pointed out that an agency, when predicating an order on its disagreement with a Circuit Court's interpretation of a statute, operates outside the law. See also Ithaca College v. NLRB, 623 F. 2nd 224, 228-229 (1980), wherein it reaffirmed the principle set forth in the above cited case (rendered by a different Circuit Court of Appeals). In that connection, the Court indicated (1) that an agency's consistent practice of refusing to follow the law of the circuit, unless it coincides with the agency's views, would be intolerable if the rule of law is to prevail, and (2) that in matters concerning interpreting the law "the final say is constitutionally committed to the judiciary."

Aside from the legal arguments militating against the non-acquiescence policy, practical considerations dictate that this policy should be discontinued. In the first place, the administrative law judges (ALJs) are caught "betwixt and between." On the one hand if they follow the rule of law set by the Circuit Court of Appeals, their decisions will be subject to criticism and reversal by the agency. On the other hand, if they follow an agency directive to ignore the Circuit Court of Appeals ruling, their decisions are subject to criticism and reversal by the United States District Court.

Equally as important is the fact that the policy of non-acquiescence fosters unfair results for claimants. In this regard, it should be noted that those claimant's who are denied at the agency level resulting from a non-acquiescence polcy, and who appeal to the Courts will prevail. However, that effort on the part of a claimant requires money, time, and a claimant's tenacity to appeal. On the other hand, claimants, who lack the tenacity and money to appeal to the Courts, and who are denied at the agency level because of the non-acquiescence policy, will not prevail. Thus, the policy of non-acquiescence promotes unequal treatment of claimants.

In view of the above, it is urged that legislation be adopted that will require the Social Security Administration to follow a Circuit Court of Appeals holding within the judicial circuit over which that Circuit Court has jurisdiction.

Another matter that I would like to comment upon is the current program being implemented by the Social Security Administration in attempting to establish uniform standards at all levels of review. The Association of Administrative Law Judges does not seriously quarrel with the policy considerations behind that effort. However, we are concerned about the manner in which it is going to be accomplished. It is our understanding that the Social Security Administration does not intend to establish uniform standards by the rule-making process under the Administrative Procedure Act (APA) whereby any proposed standard would be subject to public scrutiny and public comment before being implemented. Our Association is of the view that adoption of uniform standards without following the rule-making procedures of the Administrative Procedure Act may well be illegal. In this regard, see 44 Fed. Reg. 43265 (July 24, 1979) where the then Secretary of the Department of Health and Human Services stated that, although the Administrative Procedure Act does not make it mandatory that rule-making procedures of the APA be followed with regard to programs dealing with benefits, "the Department . . . has committed itself to observe the APA requirements." Also see 45 CFR 5.13 (a)(4) to the same effect. Furthermore, see also 36 Fed. Reg. 2532 (dated January 28, 1971) wherein the Department determined that participation by the public in the formulation of rules and regulations outweighs "any administrative inconvenience or delay which may result from use of the APA procedures." As a result, all agencies of the Department were directed to utilize the public participation procedures of the APA, 5 U.S.C. 553. Hence, the Department has placed itself under the structure of APA procedures -See Morton v. Ruiz, 415 U.S. 199, 233 (1974). Of course it is fundamental law that once an agency waives an exemption provided for under the APA, the agency must comply with the applicable rule-making procedures of the APA requiring advence notice to the public and affording the opportunity for public comment (See National Welfare Rights Organization v. Mathews. 533 F. 2d 637 (1976) - Rodway v. U.S. Department of Agriculture, 514 F. 2nd 809 (1975), Anderson et al v. Butz, 428 F. Supp. 245; State of Florida v. Mathews, 422 F. Supp. 1231 (1976) and other cases cited in 39 Federal Bar Journal 89 at 91). The Association is fearful that if the rule-making procedures of the APA are not followed, class action suits will be filed, and if successful, all cases that the ALJs have decided, using the uniform standards that were not adopted by rule-making procedures, may have to be reheard, thereby adding greatly to their current heavy workload. Moreover, our Association is of the view that the doctrine of fairness requires that any proposed uniform standard undergo the public notice, scrutiny and comment requirements of the rule-making procedures of the APA. We therefore urge that legislation be adopted that make it mandatory that rule-making procedures of the APA apply to any uniform standards that are to be developed by the Social Security Administration.

In closing, I would like to comment on certain testimony given by the Social Security Administration Officials. It is my understanding that one official stated at the hearing, that he felt that the 60% allowance rate of the administrative law judges concerning the cessation cases was not due in great part to state agency fault, but rather was due, for the most part, to administrative law judge error. That conclusion does not seem to be based on a proper evaluation of the statistical data which the Social Security Administration now has. In this connection, it is noted that Mr. Hays, Associate Commissioner of the Office of Hearings and Appeals of the Social Security Administration, testified that his office was finding a 20% error rate in the reversals made by the administrative law judges (i.e. 20% of the 60% allowances). We point out first that the so-called error rate does not mean that all of the cases were totally wrong in result. In other words, some cases are remanded to an ALJ for the taking of further evidence. In other cases the result may be correct but based on improper or incomplete rationale, and hence called an "error". However, assuming for the sake of argument that the 20% error rate of the 60% reversal rate reflects that the results reached in those cases were totally incorrect, the fact remains that 48% of the state agency cessations coming to the hearing level were made incorrectly by the state agency. (i.e. 20% of 60% = 12%, and 60% - 12% = 48%; in other words for every 100 cessation cases coming to the hearing level, 60 are reversed by the administrative law judges. Mr. Hays testified that 20% of those reversals were in error, and thus 20% of 60 is 12; 60 cases minus 12 cases leaves 48 cases having been decided correctly at the hearing level and incorrectly at the state agency level.) From the above, it seems apparent to us that when almost one-half of the cases coming to the hearing level are properly being reversed, the real focus should be on state agency reviews, and on ways to improve and correct that review process.

It is hoped that the above may be of some use to your subcommittee in formulating legislative policy.

Sincerely yours,

Chester Shatz

Chester Shatz
New England Director of the
Association of Administrative
Law Judges

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration

Refer to: SGA

Office of Hearings and Appeals
PO Box 2518
Washington DC 20013

July 21, 1981

TO: All Administrative Law Judges

FROM: Associate Commissioner for Hearings and Appeals

I am very proud and excited that Secretary Schweiker and Commissioner Jack Svahn have asked me to serve as Associate Commissioner for Hearings and Appeals. Since one of my highest priorities is to work closely with the corps of administrative law judges, I wanted my first official correspondence as Associate Commissioner to be with you. I regret that time and geography prevents this message from being delivered in person.

At this early stage of my tenure, I have three fundamental goals for OHA. First, we must assure due process for claimants and beneficiaries and improve the quality of the decisional process. Second, we must protect the rights of the government and the taxpayers. The third is more difficult: we must all work together to restore the credibility and assure the future viability of OHA and the adjudicative process you carry out.

Let me be very candid. It has been my experience that we are held in low regard by the rest of SSA, the States, the Department and the Federal Government. We are perceived by many, rightly or wrongly, as taking unreasonably different approaches to deciding cases, as having untenable reversal rates, and being generally unaccountable for our actions. I believe that you and I have a limited time to work together to correct these perceptions before solutions are imposed upon us by outside forces beyond our control.

Page 2
July 21, 1981
Memo to ... All Administrative Law Judges

I believe little is served at this point by attempting to assess blame or fault. Instead of debating whether the States, SSA or OHA are right or wrong, we must face the reality of the perceptions of the outside world and concentrate on solutions to the extent they are within our control.

I do not wish to sound negative or pessimistic. I strongly feel that by working together we can solve the problems we face I would not have accepted this assignment if I felt otherwise. I will not be able to do it alone, however. I need and want your help, and I expect you to rise to the challenge.

Let me hasten to add that I respect your decisional independence and will not attempt to interfere with it. The three goals I have outlined are entirely consistent with your decisional independence and are designed to assure it in the future. At the same time, I do not believe that one can hide behind the concept of decisional independence. I am accountable to the Commissioner, the Secretary, the Congress and the taxpayers. So too, through procedural safeguards, are you.

I look forward to working with you, through the Policy Council and other mechanisms, and talking with you when I travel around the country. Until then, I welcome and invite your ideas and recommendations for solving the problems we face.

Louis B. Hays

cc: Regional Chief Administrative Law Judges
Headquarters Executive Staff

August 5, 1981

Louis B. Hays, Esquire
Associate Commissioner
Office of Hearings and Appeals
Post Office Box 2518
Washington, D. C. 20013

Re: Substantial Gainful Activity
Your Letter of July 21, 1981

Dear Mr. Hays:

My best wishes are extended to you on your assumption of duties as Associate Commissioner. As chief executive of the free world's largest administrative legal system, you will find enough challenges to more than occupy your time.

Upon my first reading of your letter of July 21, 1981, I was angry. After a second reading, I was annoyed for reasons that follow.

With one exception, all of the goals you have set have been long-time goals of the Association of Administrative Law Judges. The Administrative Law Judges have been informed that case dispositions are at an all-time high and that quality has been maintained. We were advised that the problems to be resolved were at the "front end" of the system producing the ever-increasing number of cases being sent to the ALJ's. We were informed that Mr. Driver realized this and steps are being taken to correct the problems. One example: the District Office receives "points" every time an application or hearing request is taken in over the counter. This encourages filings to justify staff. We have reported incidents of this to Judge Gramza, Regional Chief Administrative Law Judge, Region V, in the past.

To hear from you that the credibility of the OHA's adjudicative process is questioned is a reversal of all we have been told. I learned in 1973 that some Baltimore officials would prefer to have a different system, i.e., the VA system. I'm sure they have not changed their minds. Mr. Cardwell informed a House Sub-Committee in 1974 that he wished the hearings were not covered by the APA. His concern was not credibility, but caseload. Incidentally, I believe the figures will show the ALJ system disposes of more cases per man than the VA system.

Let me also be candid. The over-all quality of the files coming to the ALJ's from the states has declined. This places development burdens on the ALJ's. We have become the garbage men of the SSA, cleaning up the files sent to us. I'm certain the states have their own problems, but that does not alter the fact.

You mention untenable reversal rates. A study would show the reversal rate involving claimants 50 and over has leaped since February, 1979, when the "grid" became effective. The Association predicted this result because the grid would mandate allowances that formerly would have been denials. Mr. Trachtenberg foresaw the same result.

Further, no one has ever explained why the SSA uses the term "reversal" to cover any case where an ALJ finds benefits are due. Our hearings are _de novo_. It is a rare case where an ALJ does not have new evidence.

Although the following list is not comprehensive, I have found benefits were due to a claimant because:

1. The claimant meets "listings";
2. The claimant was off work for 12 months because of complications unforeseen when the state agency decided the case;
3. Written acknowledgment of parentage has been found;
4. Old records have been located to establish a date of birth not available prior to the hearing;
5. The claimant was found to be insane; he had murdered his mother and shot his brother-in-law;
6. The cancer has returned after a prior cancer surgery;
7. The vocational evidence, provided by a vocational expert, establishes that the claimant cannot perform substantial gainful activity in jobs existing in significant numbers in several regions of the country;
8. New impairments have been established not ever considered by the state agency;
9. The existence of chronic and severe pain with objective evidence of conditions that would cause such pain, i.e., three spinal operations;
10. A medical advisor has testified that the claimant cannot perform basic physical functions required to work;

11. A consultative medical examiner finds that the claimant can only perform sedentary work and the state denied because the claimant does not meet listings. Vocational factors (grid) mandated benefits be awarded.

12. Tax returns not seen by the state establish insured status and, therefore, entitlement; the claimant was acknowledged disabled, but was denied because of lack of insured status;

13. The claimant amended the onset date of disability to a later date when he had insured status, or when the impairment became disabling;

14. The claimant amended the application to request a closed period of disability where he had heretofore maintained the disability was continuing; and

15. The law or regulations had changed after the state had issued its denial.

Under the law and regulations, all of the above were cases that I had to pay. If I had failed to find entitlement, I would have violated my oath of office. When I learned that all of the above are tabulated as "reversals" of the state agency, I lost all confidence in the reversal statistics of the SSA. To term all the above "reversals" is nonsense.

If an avowed enemy of the OHA hearings system, and its ALJ's, sought to devise a statistical tabulation system to make the ALJ's appear to be prodigals, it would be difficult to devise a more insidious method than the present procedure.

In regard to "accountability", that word was often used by the Carter administration when it attempted, and failed, to do away with merit selection of ALJ's and more. It has, therefore, become a trigger word with many ALJ's. The ALJ's live in a fishbowl. Our hearings are recorded. Our decisions are written and subject to the Appeals Council's own motion review and appeal by the claimant. An increasing number of claimants are represented by an attorney. There is District Court review. There are Civil Service and Departmental rules on hours and conduct and an enforcement system. If this isn't accountability, what is?

When you mention hiding behind the concept of decisional independence, I get the feeling that someone has put poison in the well. Beware of opinions of the ALJ's until you have met us. The Association of ALJ's is a very responsible group. As a four-time Vice President and two-term President of the Association, I can state that as a matter of fact. I would suggest you break bread with them.

I've been trying to obtain the Trachtenberg Transitional Team Report sent to the Secretary by Mr. Carleson of the White House. I have asked for the report under the Freedom of Information Act. I've had no response from the Secretary. Can you help? This is the confidential report that was described by Mr. Lambro in the newspapers.

Very truly yours,

Francis J. O'Byrne

Francis J. O'Byrne
Administrative Law Judge
Office of Hearings and Appeals
230 South Dearborn Street, Room 2646
Chicago, Illinois 60604

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to: SGP-2

# Memorandum

220(82)
DI-12

Date: MAY 5 1992

From: Chief Administrative Law Judge

Subject: Instructions for Implementing Change In Policy on Retroactive Cessation of Disability - ACTION

To: Regional Chief Administrative Law Judges
Administrative Law Judges In Charge
Administrative Law Judges

The purpose of this memorandum is to provide instructions on processing cases involving the retroactive cessation of disability which were forwarded to hearing offices by the DDSs prior to the Commissioner's recent decision concerning retroactive cessation.

## I. Background

The Commissioner recently decided to change SSA policy regarding when a retroactive cessation of disability will be made. "Retroactive cessation" means that the month of cessation established by the DDS in its cessation determination was prior to the month in which the 10-day due process notice was sent to the claimant.

The new policy provides that in cases where SSA is prepared to find that disability ceased, the month of cessation will ordinarily be no earlier than the month in which one of the following due process notices is sent:

A. Title II only - A personalized letter on the DDS's letterhead advising the claimant that it appears that his/her disability would cease as of a specific month and advising the claimant that he or she has 10 days to submit a statement or evidence if the claimant feels that he or she is still disabled.

B. Title XVI only - Notice of Planned Action (SSA-L8156 or SSA-L8165-U2).

C. Concurrent Cases - Notice of Planned Action (SSA-L951 and either SSA-L8156-U2 or SSA-L8165-U2).

If a copy of the due process notice is not in file, the date of the initial determination of cessation, shown on Form SSA-833, should be used.

This policy change applies only to cessation cases and not to cases involving initial entitlement in which a "closed period" is established. The policy also does not apply in cases in which: (1) the claimant voluntarily reports an earlier cessation; (2) the physician reports that at an earlier date the claimant was told that he or she had regained the capacity to work; (3) the cessation was based on work activity; or (4) the cessation was based on failure to cooperate.

## II. Case Processing

### A. Cases in Which a Hearing Has Not Yet Been Scheduled or Held

A Social Security Notice (copy attached, with instructions) has been devised to be sent by the hearing office to all claimants (and their representatives) whose cases have been identified as involving retroactive cessation; a hearing has not yet been scheduled; and the retroactive cessation portion of the prior determination can be adjusted under the new policy. The notice should be sent before any further action is taken on the case. A copy should also be retained for the claim file and hearing office file. A supply of these notices is being sent to each hearing office.

The notice advises the claimant that retroactive cessation will not be required. It also advises the claimant that he or she will not be required to repay any benefits paid for months through the second month after the month of the due process notice. The notice then asks the claimant whether he or she wishes to withdraw the request for hearing. The notice includes a tear-off form to be returned to the hearing office by the claimant within 30 days form the date it is received if the claimant wishes to withdraw the request for hearing. If the claimant does not wish to withdraw he need do nothing.

In any case in which the claimant does not return the form within 35 days (5 days for receipt after the 30 days) the hearing should be scheduled on a priority basis. In deciding the case and issuing the decision, the instructions provided below under Section B, Hearing Scheduled or Held, should be followed.

Where the claimant returns the form for requesting withdrawal of the request for hearing, the instructions below under Section C, Claimant Requests Withdrawal of Request for Hearing, should be followed.

### B. Cases in Which A Hearing Has Been Scheduled or Held

If the evidence shows that disability did not cease at any time, the ALJ should issue a fully favorable decision in accordance with existing procedures. If, however, the evidence shows that disability ceased prior to the month that the due process notice was sent (i.e., retroactively), the ALJ must consider whether such retroactive cessation is consistent with the new policy.

Where the new policy applies (i.e., none of the four exceptions exists), the ALJ should not establish a retroactive cessation date (i.e., a date of cessation prior to the month of the due process notice). Where the ALJ finds in accordance with the new policy that disability ceased in or after the month of the due process notice, the decision should include language along the following lines:

> "The Commissioner of Social Security has decided that, except under certain circumstances which do not apply in this case, the month of cessation of disability will be no earlier than the month in which the claimant was first notified by the Social Security Administration that it had determined that disability ceased. The record in this case shows that this notice was sent to the claimant in (Month, Year)."

If the ALJ believes a retroactive cessation is appropriate (i.e., one of the four exceptions to the new policy is applicable), the decision should clearly set forth the ALJ's basis for finding retroactive cessation.

### C. Claimant Requests Withdrawal of Request for Hearing

Where the claimant signs and returns the form for requesting withdrawal the ALJ should issue an order dismissing the request for hearing. As with any other dismissal at the request of the party, the claimant's signed request should be attached to the original of the dismissal order.

Philip T. Brown

Attachments

cc: Co-Deputy Chairperson, Appeals Council
Office of Appeals Operations

# OFFICE OF HEARINGS AND APPEALS
# CODING AND ROUTING INSTRUCTIONS
# SPECIAL RETROACTIVE CESSATION CASES

A. Decision changing the cessation date established by the DDS to conform to the new policy.

Decisions which otherwise affirm the prior determination except that the cessation date established by the DD is changed to conform to the new policy are considered partially favorable, but should be entered on the coding sheet for case control purposes as "AFF." However, in transmitting the decision, Form H -L502, "Notice of Favorable Decision," should be used and all copies of the decision should be stamped "EFFECTUATION NECESSARY." The decision must be routed for effectuation in accordance with existing procedures for partially favorable decisions.

B. Dismissal Where the Claimant Requests Withdrawal of Request for Hearing

Where the claimant signs and returns the form for requesting withdrawal the ALJ will issue an order dismissing the request for hearing. Form HA-515 (the blank Order) should be used in these cases. Also, where the claimant requests withdrawal of the request for hearing, a copy of the notice must be stamped "EFFECTUATION NECESSARY" and routed with the claim file for effectuation because the action in adjusting the cessation date must be implemented. The disposition should be entered on the coding sheet for case control purposes as a dismissal. Use code WI .

# Social Security Notice

From: Department of Health and Human Services
Social Security Administration

rt Name
rt Address

Date:
Claim Number:

Insert date
Insert Claim number.

rt the month/
in which the DDS
ed disability.
information
n Form SSA-833.

Insert the month/yea
of the due process
notice.

You were previously informed that your disability was found to have ceased in ______, and that the last month for which you were due benefits was ______. We have further revised our decision in your case and find that your disability ceased in ______, and that the last month you were entitled to benefits was ______. As a result you do not have to repay benefits received for any month through ______.

Insert the same
month/year shown
on the fifth line.

rt the second
h after the
shown on the
nd line.

Based on this change in our decision, you may wish to withdraw your request for a hearing on the termination of your disability benefits. If you no longer wish to have a hearing, please complete and detach the section at the bottom of this notice, and mail it to us in the enclosed postage free envelope within 30 days of the date you receive this notice. (If you wish to have your current request for hearing dismissed, you still have a right to request a new hearing on this revised decision. This request must be in writing and filed within 60 days of the date you receive this notice.)

rt the second
n after the month
n on the fourth
.

If you do not wish to have us dismiss your current request for hearing, you need take no further action and we will proceed with your pending request for hearing.

---

**Request for Withdrawal of a Request for Hearing**

Name of Person on whose Record You Applied __________ ← Insert W/E's name

SSN __________ ← Insert Claim Number

Your Name __________ ← Insert Claimant's name

I would like to withdraw my request for a hearing on the termination of my disability benefits, because of the revision in the date on which my disability was found to have ceased.

I understand that I still have a right to request a new hearing if I make this request within 60 days of the date of the notice of this revised decision.

Signature __________

Address __________ ← Insert Claimant's address

Telephone Number __________ ← Insert Claimant's phone number

COPY REQUIREMENTS: Original to: Claimant
Copies to: Representative, if any
Claim File
Hearing Office File.

NOTE: A POSTAGE-FREE ENVELOPE ADDRESSED TO THE HEARING OFFICE SHOULD BE INCLUDED WITH THE CLAIMANT'S COPY

# Social Security Notice

From: Department of Health and Human Services
Social Security Administration

Date:

Claim Number:

You were previously informed that your disability was found to have ceased in , and that the last month for which you were due benefits was . We have further revised our decision in your case and find that your disability ceased in , and that the last month you were entitled to benefits was . As a result you do not have to repay benefits received for any month through .

Based on this change in our decision, you may wish to withdraw your request for a hearing on the termination of your disability benefits. If you no longer wish to have a hearing, please complete and detach the section at the bottom of this notice, and mail it to us in the enclosed postage free envelope within 30 days of the date you receive this notice. (If you wish to have your current request for hearing dismissed, you still have a right to request a new hearing on this revised decision. This request must be in writing and filed within 60 days of the date you receive this notice.)

If you do not wish to have us dismiss your current request for hearing, you need take no further action and we will proceed with your pending request for hearing.

---

## Request for Withdrawal of a Request for Hearing

Name of Person on Whose Record You Applied____________________

SSN____________________

Your Name____________________

I would like to withdraw my request for a hearing on the termination of my disability benefits, because of the revision in the date on which my disability was found to have ceased.

I understand that I still have a right to request a new hearing if I make this request within 60 days of the date of the notice of this revised decision.

Signature____________________

Address____________________

Telephone Number____________________

OPTIONAL FORM NO. 10
JULY 1973 EDITION
GSA FPMR (41 CFR) 101-11.6
UNITED STATES GOVERNMENT

# *Memorandum*

**TO** : Chief Judge, Philip Brown **DATE:** April 26, 1982

**FROM** : ALJ, Richard F. Sprague

**SUBJECT:** Commissioner's Change in Policy Concerning Cessation of Disability

On or about April 15, 1982, our office received your memorandum giving us "instructions for implementing change in policy on retroactive cessation of disability." You informed us previously that the Commissioner had changed the policy concerning cessations. You now inform us that except for 4 exceptions, we will no longer follow the Act and Regulations on this subject, but will be limited to finding the date of cessation as of the date of the letter of the initial determination of cessation, regardless of when the claimant may have regained the ability to engage in substantial gainful activity.

While I realize that this may be beneficial to some claimants, I still don't see "by what authority" the Commissioner can disregard the "plain wording" of the Act and Regulations on this matter, regardless of his personal motives (See: Section 223 of the Act and Regulations 404.1594(b)(1)). His new policy seems to be against "basic, hornbook" administrative law.

I also am aware that the "wholesale" cessations made by the state agencies and ODO are causing some congressional and public concern. But I don't believe that this policy change does anything of substance to address this important issue. The real problem, as we know, is caused by the "wholesale" and less individualized cessations made by the lower levels. Many claimants are being ceased on little or no evidence. Some are being ceased on hasty convoluted inferences. No one objects to the underlying purpose of attempting to purge the disability roles of undeserving claimants, but there is legitimate concern and objection to the arbitrary methods now being used at the lower levels. Does the end justify the means ?

Will you please attempt to answer the questions raised, and instruct me further on this seemingly incongruous situation.

Richard F. Sprague
Richard F. Sprague

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

# MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

O : All ALJ's, HA's and HOA

DATE: May 17, 1982

REFER TO:

ROM : James M. P. D'Amico
Administrative Law Judge In Charge, Chgo-So.

UBJECT: Attached Notice of Decision And Request To Withdraw Request For Hearing

The attached notice of decision and request for hearing has been forwarded to this office for distribution to claimants in relevant cases.

I have received numerous objections from Judges which I feel cannot be ignored. The exceptions taken are not only legalistic in nature but also point out that this course of action would be detrimental to the ongoing effort of OHA to provide even the appearance of fairness. The objections are summarized as follows:

1. The OHA was established as the unbiased repository to deal with disputes between the public (claimants) and the Social Security Administration. When a case is submitted to our jurisdiction we, as Judges, are mandated by Law to protect and to adjudicate the respective rights of the parties under provisions of the Administrative Procedure Act (APA). Accordingly, when a case reaches a Judge, that Judge is the sole arbiter of of the issues presented. The attempt by the Social Security Administration to have the Office of Hearings and Appeals (OHA) send the enclosed letter does violence to the Administrative Procedure Act, the rights of the claimants and the integrity of every Judge in OHA.

2. The letter informs the claimant that (apparently for no stated reasons) WE (emphasis added) have revised our "decision." The "WE" can only be construed to collectively included Judges and the OHA in the seemingly abritrary decision to find the claimant not disabled on a given date as opposed to an earlier date. This is clearly repugnant to the mandate of decisional independence under the APA.

3. What is worse, the State Agency has already twice determined that the claimant is ineligible for continued benefits, is no longer disabled and he has elected to appeal that decision. Claimants would (by the letter) be advised that the very Agency (OHA) to whom they have appealed has already found them not

disabled albeit at a latter date. The effect of this is to create an inescapable inference that the Judges will be biased in favor of Social Security since the collective pronoun "WE" has lumped everyone in the ballpark (including the umpire) on the opposing team. It creates the appearance of impropriety.

4. There is yet more. The letter goes on to inform the claimant that despite the fact that "WE" have already made up our minds and now gratiously concede that he need not worry about paying back the overpayment he may wish to drop his appeal. The net effect is obviously calculated to chill the claimant's rights to a hearing and thus deprive him of due process of law.

5. To the extent that we as Judges and lawyers owe the claimant the duty to ensure that he receives a fair and impartial hearing, I do not see how we can discharge this duty ethically and in the highest tradition of our office and profession while allowing this to take place by doing nothing to stop it.

In view of the foregoing, I suggest that we bring this matter to the immediate attention of the Regional Chief Judge before sending any of the forms to claimants. Accordingly, I am sending a copy of this memo to the Regional Office. Each Judge will meanwhile examine his own conscience to determine what is best for him to do.

I hope we can prevail upon the Social Security Administration to recall this directive and to rectify whatever mistakes the State Agency has made at that level.

James M.P. D'Amico

James M. P. D'Amico
Administrative Law Judge In Charge

Enclosure

cc: Kenneth Stewart
Acting Regional Chief Administrative Law Judge

# Social Security Notice

From: Department of Health and Human Services
Social Security Administration

Date:

Claim Number:

You were previously informed that your disability was found to have ceased in , and that the last month for which you were due benefits was . We have further revised our decision in your case and find that your disability ceased in , and that the last month you were entitled to benefits was . As a result you do not have to repay benefits received for any month through .

Based on this change in our decision, you may wish to withdraw your request for a hearing on the termination of your disability benefits. If you no longer wish to have a hearing, please complete and detach the section at the bottom of this notice, and mail it to us in the enclosed postage free envelope within 30 days of the date you receive this notice. (If you wish to have your current request for hearing dismissed, you still have a right to request a new hearing on this revised decision. This request must be in writing and filed within 60 days of the date you receive this notice.)

If you do not wish to have us dismiss your current request for hearing, you need take no further action and we will proceed with your pending request for hearing.

---

## Request for Withdrawal of a Request for Hearing

Name of Person on Whose Record You Applied________________

SSN________________________

Your Name____________________

I would like to withdraw my request for a hearing on the termination of my disability benefits, because of the revision in the date on which my disability was found to have ceased.

I understand that I still have a right to request a new hearing if I make this request within 60 days of the date of the notice of this revised decision.

Signature____________________

Address______________________

Telephone Number________________

National Senior Citizens Law Center

NSCLC Washington Weekly

1424 - 16th Street, N.W.
Washington, D.C. 20036
Telephone (202) 232-6570

Los Angeles Office
1636 West 8th Street
Los Angeles, California 90017
Telephone (213) 388-1381

Vol. VIII, No. 19 May 7, 1982

## SSA MISLEADS DISABILITY APPELLANTS

The Social Security Administration (SSA) has indicated that it will no longer determine that a person has been overpaid when the date of disability cessation is earlier than the date of the notice of cessation. In most cases, SSA will determine that the date of cessation is the same as the notice of termination. See Washington Weekly, April 2, 1982.

SSA has issued teletypes to the states and local district offices to this effect. The teletypes also indicate that where SSA has already determined that an overpayment was created and the case is pending at any level of appeal, the date of cessation should be changed to the date of the notice of termination, thereby eliminating the overpayment.

Unfortunately, at least at the administrative law judge (ALJ) level, SSA had adopted a policy which is extremely misleading and threatens the ability of appellants to intelligently exercise their right to appeal. In cases where the ALJ changes the date of cessation and eliminates the overpayment, but where the ALJ denied disability benefits, ALJs have been instructed to issue decisions which contain a cover sheet indicating that the appellant is receiving a "favorable" decision. Philip Brown, the Chief ALJ, in a memo dated April 15, 1982, and identified as "SGP-2", instructed ALJs:

> "Decisions which otherwise affirm the prior determination except that the cessation date established by the DDS is changed to conform to the new policy are considered partially favorable, but should be entered on the coding sheet for case control purposes as "FAFF." However, in transmitting the decision, Form HA-L502, "Notice of Favorable Decision," should be used. . ."

NSCLC has already received calls from advocates whose clients were misled by the notice, believing that the ALJ had found them to be disabled.

Interested advocates should contact Eileen Sweeney or Bruce Fried in NSCLC's Washington, D.C. office or Al Chiplin in the Los Angeles office.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to: SGP-2

**Memorandum**

22 (82)
CL-19

Date FEB 23 1982

From: Associate Commissioner
Office of Hearings and Appeals

Subject: Ruling of Non-Acquiescence-Continuance or Cessation of Grandfatheree's Disability - INFORMATION

To All RCALJs
All ALJICs
All ALJs

On April 16, 1981 the United States Court of Appeals for the Ninth Circuit issued a decision holding that Supplemental Security Income (SSI) benefits based on disability to a claimant who had been converted from the State welfare rolls to the Federal SSI program in January 1974 (grandfatherees) could not be terminated unless SSA showed that there was either a material improvement in the claimant's medical condition or a clear and specific error in the prior State determination.

I want to draw your attention to Social Security Ruling SSR 82-10c in the January 1982 quarterly Rulings publication, indicating the Social Security Administration's non-acquiescence in the Court's decision. Under SSA policy, it is not necessary to show that there has been improvement in the claimant's condition or any error in the prior State determination for benefits to be ceased. It is SSA's position that a grandfatheree's SSI benefits based on disability may be ceased when the claimant's disability, as shown by the current medical or other evidence, does not meet the criteria of the appropriate State plan or the Federal criteria—i.e., the impairment is such that the claimant is able to engage in substantial gainful activity (20 CFR 416.994).

Although the ruling addresses only criteria for ceasing disability for a grandfatheree, you should be aware that the criteria for ceasing benefits based on disability also apply where the claimant is a title II or SSI non-grandfatheree beneficiary. This basic policy is reflected in SSR 81-6 (January 1981, p.27).

Social Security Ruling SSR 82-10c is binding on all components of SSA including administrative law judges and the Appeals Council (20 CFR 422.408). SSA's policy must be followed in cases involving the issue of cessation of disability, including cases involving claimants who reside within the jurisdiction of the United States Court of Appeals for the Ninth Circuit.

Louis B. Hays

cc:
Office of Appeals Operations
Co-Deputy Chairperson, Appeals Council

Endocrinology and Metabolism
Keats K. Vining, Jr., M.D
Infectious Disease
David J. Dobbie, M.D

Internal Medicine
Jack H. Townsend, M.D.
Robert S. Rood, M.D.
A. Robert Van Tuinen, M.D.
David J. Dobbie, M.D.

Drs. Vining, Townsend, Rood,
Van Tuinen, Dobbie, P.C.
Blodgett Professional Building
1900 Wealthy St., S.E.
Grand Rapids, Michigan 49506

Telephone 459-0292

January 27, 1982

Mr. Michael Basinski, Disabilty Examiner
Department of Education
Disability Determination Service
Box 1200
Traverse City, MI 49684

RE: Mr. Richard Kage A/N 385-32-9290
District: 3:MB:sab

Dear Mr. Basinski:

I am responding to your letter relative Mr. Richard Kage. The cause of his death was an acute myocardial infarction. The onset of his symptoms relating to this probably can be dated to the time of recognition of atherosclerotic vascular disease in general which would date to the time of his cerebral vascular accident several years ago which is documented in your other records supplied in the past. Any patient with insulin dependent diabetes of this age is almost always a candidate for possible atherosclerotic coronary artery disease.

As to the relationship of this to Mr. Kage's disability I will repeat what I told you on the telephone. I believe that the disability determination service standards for disability are erroneous, false and misleading. When a physician who has been entirely in charge of the patient's medical care states that a patient is totally disabled it seems totally unrealistic and completely ridiculous for any physician seeing him one time on a brief examination should countermand a statement of disability on the part of the experienced physician. On the basis of a single visual field determination on Mr. Kage's residual vision he was claimed to be no longer disabled and directed to return to work by the Disability Determination Service.

This was significantly upsetting to the patient who had consistently made some effort to remain someway gainfully employed even though he was on disability and had consistently failed to do so. He had attempted to operate a modest size business out of his home but his visual difficulties and his ability to handle order forms accurately made this a losing venture. Upon receipt of his notification of cancellation of his disability he on his own decided he would make another valliant effort and he attempted to do so. He tried exercising more, tried getting

RE: Mr. Richard Kage

around more with the hopes that perhaps he could find something to do. Needless to say, he was hopelessly depressed on the Disability Determination Service's decision feeling that it placed an additional unfair burden on his wife who was trying hard to support the two of them and was helped to some extent by his disability checks from social security.

I think the final termination of this problem speaks for itself and it is rather incontrovertable evidence that I was right and you were wrong. I think that the Disability Determination Service owes Mrs. Kage a heart-felt apology. I think that the amount of paperwork and "Mickey Mouse" caused by this set of false standards is a real tragedy.

About the time that Mr. Kage's disability was canceled another patient also from Reed City who I was seeing who worked with the post office was judged totally disabled and placed on pension. This individual had no visual difficulties and no arteriosclerotic disease of significance. His major disability was that he couldn't leave the whiskey bottle alone; he drank too much, gained to much weight, ignored his diabetic problem, and thus became a very uncontrolled diabetic all due to his own misbehavior. This was pointed out in the forms that I completed, the physical examination that I submitted; and yet, in spite of my recommendation that this man was not disabled he was given the disability. These two cases because the patients in fact were acquainted and knew each other provides the utter ridiculous contrast that points up a gross mistake in policy, principle, morals and ethics of how this Disability Determination Service functions today.

I would think that Mr. Kage's disability should be reinstated and all past monies owed him for full disability from the time of his cancelation to the time of his death should be honoroably provided with the apologies I have suggested above. This will be very little recomempence to the wife for the loss of a man who was still able to love her affectionately and be her reasonable companion.

Sincerely,

K. K. Vining Jr MD

Keats K. Vining, Jr, M.D.

KKV/srs

Endocrinology and Metabolism
Keats K. Vining, Jr., M.D.
Infectious Disease
David J. Dobbie, M.D.

Internal Medicine
Jack H. Townsend, M.D.
Robert S. Rood, M.D.
A. Robert Van Tuinen, M.D.
David J. Dobbie, M.D.

Drs. Vining, Townsend, Rood,
Van Tuinen, Dobbie, P.C.
Blodgett Professional Building
1900 Wealthy St., S.E.
Grand Rapids, Michigan 49506

Telephone 459-0292

JUN 7 1982

February 8, 1982

Ms Debra Flynn
Medical Relations Coordinator
Bureau of Rehabilitation
Disability Determination Service
P.O. Box 1200
Traverse City, MI 49684

RE: Mr. Richard Kage

Dear Ms Flynn:

Thank you for your letter relative Mr. Richard Kage. I think that it is appropriate and proper that his benefits be continued instead of eliminated. I will not review the factors involved in this case because I am sure your files contain the letters from me dealing with this situation.

However, I should like to correct one misconception that you apparently have and I think it is important for those you represent to be aware of the fact that Mr. Kage is no longer living. The treatment received by the Bureau of Rehabilitation Disability Determination Service to Mr. Kage's problems resulted in his attempt to try and work after being notified that he was now capable of working and in the process of attempting to do so and under the stress created by the termination of his disability benefits Mr. Kage had an acute myocardial infarction and died. I think the benefits that had been denied him prior to his death should certainly be provided to his widow who has worked very hard to take care of her husband.

As I have stated in previous correspondence and as I stated to Dr. Nesmith (who I know personally) this is probably the greatest example of a miscarriage of the termination of a disability determination by a bureaucracy that can't possibly function in an honest and ethical fashion. I don't care who up there realizes that I feel this way; I will say it now, and I will say it publicly that this service is a disastrous failure. At the same time Mr. Kage's disability was terminated another man in the same location (Reed City) was given disability pension who had no more license to receive it than the man in the moon; I know because I took care of him. His only disability was that he couldn't stop drinking or smoking and that is not a disability that should be compensated.

If you would like to ask me any more questions about this case and if you have anything by which you could alleviate my disdain for the Disability Determination Service I should be glad to hear from you.

Sincerely,

K. K. Vining Jr.

Keats K. Vining, Jr, M.D.

KKV/srs

## Selected Case Studies

Case #1: (Mr. R)

Age: 54
Date Found Disabled: 4-22-78
Wife, Daughter (under 18)

May 22, 1978 -- Application for Disability

Lists heart disease, angina, hypertension as disabilities. Patient employed February 1956-April 1978. Worked as slitter operator on appliances. Job required much bending and lifting, "and mental stress." Disability Report states that illness first bothered Mr. R. on January 22, 1976; suffered heart attack. In 1977, treating physician (Dr. K) had told Mr. R. not to work overtime and to perform only light work. States that in the past six months, difficulties in performing job arose. "I began to make mistakes I never made before, and my work quality was starting to get poor and made me feel depressed." According to report, Mr. R. suffered chest pains and shortness of breath while at work.

May 26, 1978 -- Treating Physician's Report

Treating physician's (Dr. G's) prognosis for patient's return to usual work: "never."

August 20, 1981 -- Profile CDI Initiated.

December 28, 1981 -- DDS Requests Current Evidence on Claim.

December 31, 1981 -- Patient Files Disabled Person/Vocational Reports

Contact Report of January 7, 1982, states last hospitalization was in June 1978 due to chest/stomach pains.

February 3, 1982 -- CE Scheduled by DDS.

Dr. K. reports that another cardiac catherization is scheduled for Mr. R. (Last was performed in 1977.) "Patient's symptoms are that he has chest pains in the midchest area; pains are sharp -- sometimes an aching pain, but most of the time it comes at rest at least two to three times a day..." Doctor's impression includes "likely unstable angina."

February 11, 1982 -- Notice of Pending Cessation

States that due to Mr. R's heart condition, special tests indicate that he should avoid heavy lifting. DDS recognizes that he cannot return to past work as slitter operator. At his age (53) and educational background (8th grade), however, DDS finds Mr. R. qualified for sorting/assembling jobs not requiring much physical exertion.

February 23, 1982

DDS grants extension to March 4, 1982 for submission of additional medical reports. Yet Mr. R's file no longer in office which made determination to discontinue benefits -- had been forwarded to Baltimore.

March 3, 1982 -- Treating Physician's Report

Dr. M. writes that patient is hypertensive. "Sudden onset of severe pain" in 1976 required hospitalization. Patient returned to work until April 1978. Due to "progressive pain," a cardiac catherization was performed in 1977. Patient admitted to hospital again in 1978 for study of abdominal pain. According to Dr. M., "The patient's complaints are characteristic and, by history, are not improved since 1978 but indeed are increasing." Doctor cites bouts of generalized chest pain and dizziness. Patient has shortness of breath.

Physician notes patient "extremely apprehensive" and anxious during interview.

Patient "found not gainfully employable.'

Dr. M. also contends that range of tests to which Mr. R. has been exposed show lack of clinical judgment due to condition of his health.

March 8, 1982 -- DDS Evaluation of Physical Residual Functional Capacity

Finds Mr. R. able to perform light work. . Ability to work regained as of January 1982, according to DDS. Last check will arrive in March. Rationale sheet states relevant past work was heavy. Skills not transferrable.

March 23, 1982 -- Termination Notice

Received by Mr. R. and wife, Diane.

Case #2: (Mr. B)

Age: 56
Date Found Disabled: August 11, 1976
Unmarried, no dependents

Background:

Mr. B. has undergone 16 operations since 1976. Bladder, prostrate, appendix, some lymph nodes, and portions of the colon were all removed due to cancer. He had two surgeries for bowel obstructions in 1977. He has a hernia which protrudes excessively around stomach region. Suffers from abcesses and gallstones. Doctors performed an ileostomy in order to redirect Mr. B's urine -- since then he has had to wear a urine bag. Mr. B also wears an abdominal support due weakness of the abdominal wall (the result of numerous surgeries). Permanent tubing protruding from his back performs function of kidney drainage. Patient must be hospitalized every month in order to have tubes changed. He has no control of his bowel movements. He complains of pain across his shoulders which radiates down through his lower back. He has shortness of breath and suffers from pain (arthritis) in his hips at exertion. Has difficulty sleeping at night, is hypersomulent during day.

Mr. B. has worked as a carpet weaver, welder, draftsman. Has not worked since 1976.

## May 17, 1979 -- ALJ Rules to Restore Claimant's DI Benefits After Review

Memorandum states that while SSA had determined that Mr. B. had regained capacity to work as of August 1978, "the evidence of record shows that there is a reasonable medical basis for the claimant's subjective complaints." According to the ALJ, the claimant's treating physician had reported that "as a result of the claimant's general condition, he is unable to particiate in normal working types of activities." He is restricted from doing any type of "even moderate manual labor." Patient is being treated for hypertension, colitis, and arthritic condition of the hip joints. He demonstrates evidence of liver malfunctioning. Patient suffers "extreme" pain in both hips and back, tires from even mild exertion, has difficulty breathing, and cannot control his bowel movements and urine. On the basis of these complaints, impairments, "the Administrative Law Judge finds that the claimant continued to be prevented from satisfactorily engaging in any substantial gainful activity."

## November 23, 1981 -- Quality Review Report

Finds that beneficiary failed to report change in medical condition. Carcinoma of bladder successfully treated with surgery. "Due to weakened abdominal wall from the surgery, the beneficiary...should have been able to return to less strenuous work." Accordingly, decisions to continue his claim were incorrect. Medical evidence shows beneficiary's condition "is unchanged and is not disabling." Date of cessation set at 6/79 (one month after more recent ALJ decision).

## December 22, 1981 -- SSA Request for Case Action

## January 13, 1982 -- SSA Requests Current Evidence of Disability

States that since last such report, Mr. B. has developed an incurable disease of the kidneys. "I have two tubes coming out of my back for drainage of the urine." Cannot travel for fear of jarring tubes or of "accidents."

## February 25, 1982 -- Report of Contact

Dr. C. reports that he saw patient today. Information requested by SSA, however, can be obtained from claimant's urologist.

March 8, 1982 -- Treating Physician's Report

Dr. T. reports to DDS that Mr. B. had diagnosed carcinoma of the bladder in 1976, has pains in his hips that prevent him from walking more than one or two blocks, shortness of breath on exertion, and frequent abdominal pains. "He is unable to work."

March 19, 1982 -- Notice of Pending Cessation

Regained ability to work in March 1982.

Explanation of determination states that based upon reports of Dr. C. (report of contact 2-25-82) and Dr. T. (3-8-82) "your cancer was successfully treated with surgery and radiation. To date, there is no evidence of this disease spreading. Recent blood tests show that your kidneys function normally. The remainder of your physical examination is normal. You have no impairments that would be considered disabling at this time."

March 29, 1982 -- Treating Physician's Report

Based on examination of Mr. B on 3-26-82, Dr. M. states, "He [patient] continues to have weakness of his abdominal wall, increased since my last examination. He has bilateral drainage of his kidney, posteriorly...he has a very weak abdominal wall because of the extensive abdominal surgery he has had in the past, and I have restricted him from doing any type of manual labor."

March 30, 1982 -- Request for Reconsideration

Mr. B. claims he cannot control his bowels. Report of Continuing Disability states, "I can't get out in winter, urine freezes, accidents occur." Lists as difficult: walking, taking care of all personal needs, using public transportation. "Can't stoop or kneel; can't lift anything over 5 lbs. Must be careful people don't bump into me [due to tubes]."

April 29, 1982 -- Determination and Transmittal

SSA determines Mr. B. regained ability to work. Last check will arrive 5-82.

Disability Determination Rationale states reports of Drs. C., T., and M. were considered. "Claimant was initially found disabled due to carcinoma of the bladder. Current medical evidence reveals that this disease was successfully treated with surgery and radiation therapy. The tumor was entirely resected with no evidence of recurrence or metastasis. Current kidney function test is normal as is the remainder of his physical examination."

May 4, 1982 -- SSA Notice of Termination

Case #3: (Mr. R.B.)

Age: 53
Date Found Disabled: March 3, 1976
Wife, 2 dependents

Background:

Patient suffers from Lupus (or SLE), a disease characterized by skin lesions and joint pain, first diagnosed over 25 years ago. A former steel company supervisor (and later a manager of a dry cleaning service), Mr. R.B. has a history of hypertension and recurrent renal stones. (He has had 8 removed.) Despite medication, his condition so progressively worsened that at age 42 painful joints and lethargy (fatigue) became "incapacitating," according to medical reports.

By 1980, Mr. R.B.'s disease had spread widely throughout his body. Pain and stiffness made movement difficult. (Skin bleeds periodically.) Lupus involvement of the lungs was suggested by his symptoms.

August 19, 1981 -- CDI Profile Initiated

October 12, 1981 -- DDS Notifies of Review Process

December 19, 1981 -- Treating Physician's Report

Dr. L., who has treated Mr. R.B. throughout the years, reports that he was hospitalized several months ago due to back pain. Was found to have a ruptured disc and compression fractures of the spine. Underwent surgery; recent episodes of hematuria (blood in the urine) are felt to be secondary to his kidney stones. "He has continued to have active skin disease and joint pain."

January 8, 1982 -- DDS Notice of Consultative Examination

January 12, 1982 -- CE Physician Reports

Dr. S. notes that patient "has severe fatigue, even at rest, pains almost over all of his body, and recurrent hematuria." History of hypertension, psychiatric illness, exertional dyspnea and dizziness. "He has a chronic pain, almost in every joint of his body attributed to his lupus disease." Patient has a history of gradually worsening symptoms, according to Dr. S., who concludes, "In my opinion, I wonder if he will be able to do any gainful employment."

January 27, 1982 -- Notice of Pending Cessation

States that medical reports show that while patient has lupus erythematosus, "it is not causing severe problems." Cites fairly good blood pressure and stable heart condition. Despite patient's back surgery and continuing stiffness of the spine, DDS has determined that he is able to sit, stand, walk, stoop and bend "without significant difficult." Finds Mr. R.B. able to return to former employment (as a dry cleaners manager) as of January 1982.

February 3, 1982 -- Treating Physician's Report

Dr. L. feels that, at this time, Mr. R.B. "has too many ongoing medical problems to seek gainful employment." Continues to suffer from joint pain, hematuria, extreme fatigue. Due to structural weakness of the bone (osteoporosis), Mr. R.B.'s dosage of medication is being reduced, making his condition unstable.

As to DDS's determination that Mr. R.B. can return to his previous work, Dr. L. disagrees: "He had difficulty doing that, and was advised by his previous internist and pulmonary specialist that he should not pursue the cleaning business any longer because of the effects of dry cleaning chemicals, dust, and steam in the cleaner's plant."

February 9, 1982 -- Mrs. R.B. Notifies Senator Levin

Reports that following receipt of notice of pending cessation, her husband was given 10 days "in these red alert snow blizzards" to submit additional medical information. "My husband has difficult and painful mobility and cold termperature sensitivity and is experiencing a severe kidney bleeding problem since October 1981, so this was a physical impossibility for him." Notes that husband's options are narrowing with regard to medications due to deteriorating side effects. "He is enduring more physical pain and itching than ever. He has had two to three lengthy hospitalizations each year in the past five years."

Reports that, during CE, the Social Security doctor took one vial of blood, an EKG, and the patient's blood pressure. No urine analysis was taken despite the relevance of a specimen to patient's condition. "My husband brought his medical documentation to the Social Security doctor, and it was not even looked at."

February 10, 1982 -- Treating Physician Reports

Dr. R., Director of Nephrology at the County Hospital, states: "Mr. R.B. is severely disabled by the complications of systemic lupus erythematosus and his treatment. He is unable to be gainfully employed in any occupation."

March 2, 1982 -- Continuation Sheet for Disability Determination

Determined applicant's disability ceased 1-82; benefits ineffective as of 3-82. Rationale statement reports patient's SLE "under moderate control. There is some renal involvement with renal stones." Residual functional capacity found to perform light work. Patient may return to dry cleaners industry since job required lifting up to 20 lbs and standing/walking 6-8 hours.

March 15, 1982 -- Social Security Termination Notice

Case #4: (Mr. A)

Age: 59
Date Found Disabled: 3-5-80
Wife, No Children

August 13, 1980 -- Application

Mr. A. states that since May 1975 he has suffered from degenerative arthritis of the lower spine. This illness makes it painful to walk; he claims the pain is constant.

Mr. A. worked as a tool maker since 1942. For the past four years, his work has been limited because of his back condition. He no longer partakes in recreational activities such as hunting and fishing.

On June 7, 1978, Dr. O. advised Mr. A. not to work overtime. On September 13, 1978, Dr. S. concurred.

August 22, 1980 -- Treating Physician's Report

Dr. W. agrees with earlier assessment by Dr. H (June 23, 1980) that Mr. A. "is not fit to return to strenuous work or any job requiring repetitive bending or lifting or long periods of standing or sitting without position change.

August 27, 1980 -- Vocational Report

DDS evaluation of physical residual functional capacity found the claimant's capacity for exertion full range in the Sedentary work category. However, skills were deemed "not transferable," therefore there was no job available which he could perform.

September 1, 1980 -- Claimant Enters Disability Program

July 29, 1981 -- CDI Profile Initiated

October 28, 1981 -- DDS Notifies Claimant of Review Process Requests

November 24, 1981 -- Treating Physician's Report

Dr. W. reports on Mr. A's condition since March 1980. Concludes that he is "no better" and must avoid strenuous activity, bending, and sudden motion, for these exacerbate the pain. According to Dr. W., "the patient continues to be disabled."

A March 6, 1981, prognosis by Dr. O. is poor. Patient's disability was aggravated by employment.

Dr. H., orthopedic surgeon, notes that Mr. A. attended back education classes and underwent physiotherapy that there was no sign of "pathology beyond advanced degenerative changes in the patient's spine."

December 9, 1981 -- Consultative Exam Report

Dr. S. finds Mr. A's symptoms to be "continuous pain in the lower back which is made worse by overexertion, bending, lifting..." According to report, Mr. A. walks with a cane. Doctor's impression includes history of hypertension, degenerative arthritis of the spine, obesity, and status post right eye cataract surgery. Concludes that Mr. A's activity is limited due to aggravation of the symptom.

December 11, 1981 -- Expansion of CE Report

Dr. S. contacted to determine whether patient can walk without ambulation aid. Answer affirmative.

December 16, 1981 -- Notice of Pending Cessation

SSA finds that although Mr. A. feels pain when he moves his back, he is capable of walking, standing, sitting, and bending for "significant" periods of time. Mr. A. found able to return to his usual job as of December 1981. Benefits will cease February 1982.

December 30, 1981 -- Claimant Files Additional Medical Reports

Mr. A. informs DDS of forthcoming physicians' reports. Criticizes Consultative Examination calling it, "the worst I've ever had." Mr. A. says Dr. S., the Examining Physician, merely took blood pressure, asked him to bend over, lie on his back -- "paid no attention at all" to the fact that he required support for his head when lying on his back, requested tests irrelevant to his main problem, did not have all medical reports and none from Dr. O, who has treated Mr. A. since 1966, was unaware of his back lessons at General Hospital where he was taught to live with the pain. Mr. A. concludes his letter by noting that his former company will not allow him to return to work due to his back condition.

January 26, 1982 -- Treating Physician Report

Dr. W. reports that patient's repeat physical of January 19, 1982, shows that he suffers from "steady low back pain." Concludes that "it is likely that the patient's symptoms will continue."

February 1, 1982 -- Social Security Termination Notice

Received by Mr. A. and wife. Benefits will cease February 1982.

Case #5: (Ms. H.)

Age: 36
Date Found Disabled: 9-5-74

Background:

On June 27, 1974, treating physician, Dr. S., prescribed an "indefinite medical leave" for patient -- has not allowed her to return to work since. Symptoms of Ms. H.'s condition include muscle weakness (due to steroids and lack of mobility), musculo-skeletal pain, idiopathic lasceration (angioedemia), severe inflammation, bruising, joint inflammation, bone splints (bone weakness), obesity. Most obviously disabling symptom is urticaria (hives) -- painful inflammation, burning and itching, rendering joints immobile. Inflammation of feet, hands render them useless. Internal involvement results in severe chest pains radiating to the neck and jaw. Facial disfigurement. Activity and pressure exacerbate symptomology. Cushing's Syndrome symptoms include muscle weakness and general bodily malaise, propensity to bone fractures. High blood pressure and obesity are results of steroid therapy. With therapy (steroid treatment; Prednisone, symptoms become more severe, even life-threatening. Vigorous approach to reducing steroid intake involves reduction in activity, reducing the need for steroids.

February 6, 1975 -- Treating Physician's Report

Dr. S. states, "she has failed to improve on the usual antihistaminic therapy and has required large doses of steroids to control her... incapacitating uricaria which interferes with her daily activity." Of Ms. H.'s therapy, Dr. S. states,"By interrrupting her occupation a significant reduction in the Prednisone been accomplished. This has been performed in an effort to avoid the life threatening complication of high-dose steroid therapy." Dr. S. concludes, "It is impossible to prognosticate the duration of her current symptoms."

February 25, 1976 -- ALJ Rules in Claimant's Favor

Based on application filed on 12-23-74, Ms. H. found disabled on 9-5-74.

March 7, 1975 -- Treating Physician's Report

Dr. G. reports, "Although there is a possibility of remission, I would consider it quite unlikely." Tells SSA that Ms. H. "asked me to discuss the fact that the disease had disabled her and affected her ability to function normally with the swelling, pain, joint swelling, and breathing difficulties, as well as the side effects of antihistamines and steroids. This is true." Dosage of steroids will result in considerable complications.

June 18, 1975 -- Treating Physician's Report

Dr. S. reports of patient's condition/symptoms, "Ms. H. has experienced marked inpairment of function, consequent to these manifestations."

September 29, 1975 -- Treating Physician's Report

Dr. A., patient's gynecologist, reports, "Having treated Ms. H. since January 1972, and having observed her chronic idiopathic urticaria and her response to medication, it is my opinion that she is not capable of carrying on any full-time employment.

February 1981 -- Steroid Withdrawal -- Hospitalization

October 1981 -- Vasculitis -- Hospitalization

January 21, 1982 -- Treating Physician's Report

Dr. S. reports following examination of January 19, 1982. Says of patient, "She developed exacerbation of her symptoms following upper respiratory infection." Dr. S. suggested hospitalization. "It was felt that she could not resume gainful employment at this time."

Addendum of February 5, 1982, states that patient has developed hypertension "at a dangerous level" due to treatment of recurrent urticaria. "Antihistamines have been added to the program in an effort to reduce the Prednisone which at times can be so [sleep inducing] that she cannot function in a gainfully employed position. If these drugs are not administered, the urticaria flare, with marked "involvement of the joints and soles to the point that she is disabled."

February 1, 1982 -- Notice of Pending Cessation

DDS informs Ms. H.: "Evidence in your file shows your condition no longer prevents you from working." Ability to work regained 1-82; last check will arrive 3-82.

February 8, 1982 -- Physician's Report

Dr. B. tells DDS that patient "is totally disabled from any form of gainful employment because of her small vessel vasculitis manifesting with chronic urticaria and multiple sympomatology."

March 3, 1982 -- Physician's Report

Dr. R. tells Ms. H. that she has developed thyrotoxicosis.

March 12, 1982 -- SSA Notice of Termination

Last benefit payment is for month of March 1982. Hospital and medical insurance coverage under medicare ends last day of April 1982.

March 17, 1982 -- Request for Reconsideration

Ms. H. states "The decision was made contrary to and with disregard for the medical evidence in file. Also, I was denied a request for Medical Exam by one of the Administration physicians."

March 26, 1982 -- Treating Physician's Report

Dr. S. states, "Ms. H. has significant and marked impairment of all functions consequent to her disease, preventing her from performing in a continuous manner any duty or engaging in any type of gainful work activity. In addition, her medications further compromise her ability to engage in gainful employment."

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31 Exchange Street, Lynn, Massachusetts 01901 (617) 598-0800

STEPHEN J. KEHOE
JURA STRIMAITIS
JOAN LENINGTON
MARK BRONSTEIN

MYRA KORINS
OFFICE MANAGER

May 6, 1982

Senator Carl Levin
140 Russell Building
Washington, D.C. 20510

Attention: Ms. Jackie Parker

Dear Ms. Parker:

I am writing at the suggestion of Richard Dutka of the law firm of Petkun & Locke who has informed me that you are interested in hearing about individuals who, although clearly disabled, had their SSDI benefits terminated.

I recently represented such an individual, [Mr. F.] and have enclosed herewith the letter which I wrote to the administrative law judge assigned to his case. After reviewing the record, and without the holding of a hearing the judge reversed the state Disability Determination Service's decision terminating [Mr. F.'s] benefits.

Although ultimately unsuccessful, the attempt to terminate his benefits has had a serious impact on [Mr. F.] and his family. He and his two children have been without an income since June of 1981 and it may be several more months until they actually receive checks for their past due benefits. In addition to the financial aspect, the entire process has been extremely upsetting to all concerned, not to mention its effect on [Mr. F.] medical condition. It also impacted on [Mr. F.] parents who, despite their own serious medical problems, took [Mr. F.] back into their home when he could no longer afford to live on his own.

As to why he was terminated in the first place, it has been my experience that the Disability Determination Service refuses to take mental impairments seriously unless they render the claimant almost completely nonfunctional.

I would be happy to forward any additional information which you might request.

Sincerely yours,

Mark Bronstein

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STEPHEN J KEHOE
JURA STRIMAITIS
JOAN LENINGTON
MARK BRONSTEIN

MYRA KORINS
OFFICE MANAGER

March 17, 1982

Chester Shatz
Administrative Law Judge
Office of Hearings and Appeals
55 Summer Street
Boston, MA 02110

Re: [Mr. F.]

Dear Judge Shatz:

This office represents the above-named claimant whose appeal of the termination of his Social Security Disability Insurance Benefits has been assigned to you for hearing. This letter is to bring to your attention the pertinent facts of this case and to suggest that the record is totally devoid of any evidence which would support the Disability Determination Service's decision that [Mr. F.] condition has improved to the point that he is able to now engage in substantial gainful activity.

In 1973 [Mr. F.] underwent brain surgery as a result of a cerebral aneurysm which left him with a form of permanent brain damage known as frontal lobe encephalomacia. As a result of this condition as well as other medical problems including hypertension, heart difficulties, hypothyroidism, and alcoholism, he was awarded SSDI benefits. The physician who performed the consultative examination upon which the Social Security Administration relied in granting [Mr. F.] benefits was Leonard R. Friedman, M.D. Since that examination [Mr. F.] began to treat with Dr. Friedman whom he still sees periodically. On June 1, 1981 [Mr. F.] was admitted to the Bournewood Hospital in Brookline for severe depression. He was discharged by Dr. Friedman on June 29, 1981 with a final diagnosis of "Psychotic Depression; Organic Brain Syndrome with Frontal Damage".

On his last day at Bournewood [Mr. F.] was examined at the request of the SSA by Dr. Stuart Clayman, a clinical psychologist. Dr. Clayman's conclusion was that [Mr. F.] while of average intelligence was suffering from "non-psychotic organic brain syndrome, with memory deficit and perceptual problems" and "depressive neurosis, severe."

Subsequently in a July 23, 1981 report, Dr. Friedman, relying in part on Dr. Clayman's assessment, stated that his original diagnosis of [Mr. F.] in 1975 had not changed except that in addition he now had a "unipolar psychotic depression -- severe and unimproved." His final conclusion is worth quoting in full:

> The patient's hypothyroidism was untreated until 1981 complicating his depression and accounting for his three hundred plus pounds. In addition, he is only now on anti-depressant medication. He did not function well in a social situation in a hospital. Due to his brain damage, I don't see him capable of vocational rehabilitation. I believe his hallucinations and suspiciousness point to his underlying psychosis at this time, which also handicaps him. He is completely disabled from the job market at this time because of his illness.

Two weeks after this letter was written [Mr. F.] took a turn for the worse and from August 4, 1981 until August 14, 1981 and then again from August 30, 1981 until September 6, 1981 [Mr. F.] was hospitalized at Huntington General Hospital in Boston. His discharge diagnosis on September 6th states "depressive neurosis, frontal lobe encephalomacia, hypothyroidism, diabetes mellitus."

On October 12, 1981 Dr. K.L. Tyler performed a neurological examination of [Mr. F.] at the request of the SSA. His report indicates in part that [Mr. F.] had a "flat affect", poor memory, a general loss of initiative, depression as well as a number of medical problems. The report gave no indication that he had the functional capacity to perform substantial gainful activity.

Having summarized what I believe is all the medical evidence in the record, it should be clear that in his current condition [Mr. F.] clearly meets the criteria contained in the Mental Disorders section of the Listing of Impairments, 20 CFR Section 404, Appendix 1, Section 12.00.

In my own opinion, it is particularly ironic that Disability Determination Service terminated benefits in this case despite the fact that the physician who performed the consultative exam on which the 1975 decision to award benefits was based now states that if anything the claimant's condition has worsened. Given the above, I would respectfully suggest that the evidence currently in the record warrants a decision wholly favorable to the claimant and that therefore a hearing is unnecessary.

If you determine that a hearing is warranted, we are prepared to proceed at your earliest convenience.

If there is any further information which you would find helpful, please do not hesitate to contact me and I will make every effort to assist you.

Sincerely yours,

Mark Bronstein

**Protection & Advocacy Incorporated**

Designated by the Governor
to protect and advocate for
the rights of Californians with
developmental disabilities

MEMORANDUM

To: Jackie Parker in Senator Carl Levin's Office

Re: [Mrs. McG.]
Age 37 - SSN

Redlands, California 92373

[Mrs. McG.] had been receiving SSDI for herself and her daughter since 1976. She received $699 for herself and for her 12-year-old daughter Margaret. She receives $50 a month child support. Her rent is $375 a month. Her last check was in February. The termination of SSDI has also meant that her in-home supportive services have also been terminated. These IHSS services, funded by Title XX and disability linked, are for the purpose of providing homemaker chore and attendant care services needed by a disabled person in order to remain in his or her own home.

[Mrs. McG.'s] primary disability is an auto-immune disease, probably lupus or scleraderma or rhuematoid arthritis. She is down to 95 lbs. at 5'6 3/4" She has had two Harrington rods placed in her back. She walks with difficulty with a cane. The auto-immune disease and concomitant deterioration of the connective tissue has meant a loss of stamina and a very limited ability to do any physical activity. The medications she is taking has made her very sensative to light and she must wear dark glasses. She suffers from a lot of joint pain. Her jaws are freezing shut. She must take prednisone in order to keep her digestive track open. In August of 1981 she underwent major abdominal surgery which was as a result of her auto-immune disease.

[Mrs. McG's] secondary disability is epilepsy. The epilepsy appears to be manifest by tremors with seizures as severe headaches involving right side of face numbness, loss of equilibrium, and nauseau, all of which lasts one to three hours. Following the severe headache-seizure she will have a period of confusion which varies in length from a couple of hours to a couple of days. (Mrs. McG.]reports that during the period of confusion she has difficulty putting things together. She also has loss of memory.

. . . . . . 2

Community Advocacy Office
1636 West Eighth Street, Suite 211
Los Angeles, CA 90017
213/383-7285 800/952-5746

These incidents occur several times a month. It may be that some of the complaints identified as epilepsy may be related to the auto-immune disability.

[Mrs. McG.s] primary treating physician is A.J. Reisch, M.D., a rhuematologist, telephone 714-883-8611. She is also treated by Robert Klein, M.D., a neurologist, telephone 714-883-9305.

In July of 1981 both she and her physician filled out and returned disability questionnaire forms.

In September of 1981 [Mrs. McG.] underwent a consultative examination by Dr. Hagland, a pulmonary specialist. She has not seen a copy of the consultative report.

In December of 1981 [Mrs. McG.] received a communication from SSA indicating that based on their review of the record they determined [Mrs. McG.] was able to work in September of 1981. Although the December 1981 notice indicated December was her last check, she continued to receive her January and February check. She received a final-final notice in February.

Her physician, Dr. Reisch, submitted a detailed report in response to the December 81 notice. He sent another report in response to the February notice. [Mrs. McG.] is presently in "reconsideration". Her physician has sent yet another report because Social Security cannot find either the report sent in response to the December notice or the report sent in response to the February notice.

[Mrs. McG.] has been told that the reason she was found no longer disabled was because a "LEA" blood test registered false negative and did not show a positive result for lupus.

[Mrs. McG.] is someone the janitor could tell was disabled from across the street.

MH/olf

Appealed I.H.S.S. action and as of 5/5/82 it was reinstated. County of San Bernardino.

**Legal Center For The Elderly**
EL DORADO COUNTY
937 SPRING ST. - PLACERVILLE, CA 95667
TELEPHONE (916) 626-2388

May 17, 1982

Ms. Jackie Parker
Office of Senator Levin
140 Russell Senate Office Building
Washington, D. C. 20510

Dear Ms. Parker:

I apologize for not being able to write to you sooner and for including only the one case history. My office has represented over 200 people in social security and SSI appeal hearings, and I am certain I could come up with several more cases that would interest you if I had the time to search through my files.

As I understand it, the bill you have introduced would provide for continuation of Title II social security disability benefits until there has been a hearing on cessation of disability for medical reasons. I feel that this is an extremely important issue, and your bill would cure the greatest inequity which now exists in the social security disability system.

In California, a person who is both poor and disabled, is entitled to an SSI benefit in the amount of $439.00 per month. If the Social Security Administration decides that this person's disability has ceased, the benefits will still continue through the time of the administrative hearing. In my experience, we are successful in over 75% of the hearings on termination of disability, and therefore these SSI recipients will have, at least in theory, no interruption in their benefits. The inequity arises when a person is entitled only to regular social security disability benefits. For example, if a person is disabled and receiving $460.00 per month in social security disability benefits, his or her income will

LEGAL CENTER FOR THE ELDERLY

Ms. Jackie Parker
May 17, 1982
Page Two

be immediately reduced to zero when the Social Security Administration gets the idea that the disability has ceased. Even though we may eventually be successful at the hearing level, the recipient will be without income for periods of up to between eight months to two years. During this period, the client is likely to experience eviction from his or her home, foreclosure, repossession of vehicles and shut-off of utilities.

Please let me know if there is any further information with which I might be able to assist you.

Very truly yours,

George Appelbaum

George Appelbaum
Staff Attorney

GA:seg

Enclosure

CASE A

A.C., a 47 year old railroad construction worker, was first found disabled as of March, 1972, because of a serious work related accident. At that time, he was 37 years old. He remained on disability benefits until March, 1981, at which time he received a termination notice. The termination was apparently based on reports of Drs. Lovell (see attachments A2 and A3) and Smith (see attachment A4). Dr. Smith was the man's personal physician and Dr. Lovell was the social security referral physician. Nothing in either report suggests that the man is able to go to work.

The claimant requested reconsideration on May 6, 1981. On May 8, 1981, the Social Security Administration again decided that Mr. C. was ready for work. It again cited the same two reports and stated "The claimant retains the capacity to sit 6 to 8 hours per 8 hour work day with occasional standing/walking, lift 25 pounds maximum and lift/carry 10 to 15 pounds frequently." This is a total fiction. Nothing in any report suggests that the man can perform these tasks. Notice here the sequence of dates. Mr. C. requested reconsideration on May 6, 1981; the Administration reconsidered his claim and decided against him a mere two days later. However, it did not notify him that he was being turned down on reconsideration until July 28, 1981.

On September 16, 1981, Mr. C. requested a hearing. A hearing was finally held on April 22, 1982. Immediately following the hearing, the administrative law judge notified us that he definitely considered Mr. C. still disabled, and that there was no evidence that his condition had improved or that he was able to do any sort of work. The written decision by the administrative law judge was received on May 3, 1982.

Mr. C. has now been without income for more than one year.

LEGAL AID FOUNDATION OF LOS ANGELES
8601 SOUTH BROADWAY • LOS ANGELES, CALIFORNIA 90003 • (213) 971-4102

January 22, 1982

Social Security Administration
Office of Disability Operations
Baltimore, Maryland 90059

Re: [Mr. W.]

Dear Sir/Madam:

My client, [Mr. W.] , has been unfairly cut off his disability insurance benefits.

Your letter regarding his disability of January 8, 1982 states that: "Information is needed to determine whether you are still disabled although you have been requested to furnish the required information, it has not been submitted."

This is not true. On December 8, 1981, a five page single spaced psychiatric analysis of [Mr. W.] sent, certified mail, #714417, to Ms. Gloria Spoon, Disability Evaluation Analyst, who was responsible for said case. Either Ms. Spoon did not receive said mail or has intentionally or negligently failed to acknowledge receipt of this vital or "required information". At any rate, considering the malcondition of [Mr. W.] , it borders on the irresponsible for him to be cut off from Social Security Benefits. A mere perusal of the December 1, 1981 report by Dr. Amos Davis would make any reasonable person enraged at a man of [Mr. W.] poor condition being illegitimately deprived of his Social Security Benefits.

Since this is Disability Insurance Benefits [Mr. W.] is being deprived of his aid pending resolution of this matter. This is outrageously unfair and will result in severe permanent damage and hardship to him and his family. Thus it is imperative that [Mr. W.] period be restablished so he may continue to receive his benefits while the Disability Evaluation

-2-

Department of the State of California correct their misevaluation of [Mr. W.]

Sincerely,

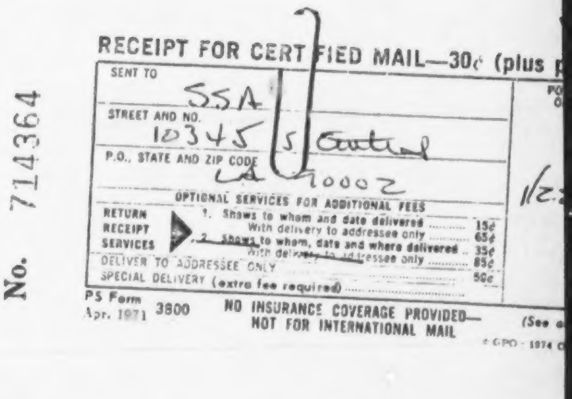
M. LUMUMBA UMOJA

/amc

cc:

Maxine Waters
Augustus F. Hawkins
Bill Green
Alan Cranston
SSA -10345 S. Central, L.A.

#714365



No. 714364

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10345 S Central

P.O., STATE AND ZIP CODE
LA 90002

1/2

OPTIONAL SERVICES FOR ADDITIONAL FEES

RETURN RECEIPT SERVICES
1. Shows to whom and date delivered .......... 15¢
With delivery to addressee only .......... 65¢
~~2. Shows~~ to whom, date and where delivered .. 35¢
With ~~delivery to addressee~~ only .......... 85¢
DELIVER TO ADDRESSEE ONLY
SPECIAL DELIVERY (extra fee required) .......... 50¢

PS Form 3800
Apr. 1971

NO INSURANCE COVERAGE PROVIDED—
NOT FOR INTERNATIONAL MAIL

(See

GPO : 1974

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40 Court Street, Suite 510
Boston, Massachusetts 02108
(617) 742-7146

May 7, 1982

Jackie Parker
Senator Carl Levin's Office
140 Russell Building
Washington, D.C. 20510

Dear Ms. Parker:

As per your request, I am enclosing the basic facts of a few cases in which the Social Security Administration terminated benefits on the basis of insufficient evidence and in an arbitrary manner. I have not yet been able to contact these clients so, again, these names are to be kept confidential until you hear otherwise.

[Ms. L.] is 46 years old and has a 10th grade education. She has worked as a meat packer her whole life. In August, 1972 she suffered an industrial injury to her back and she has been out of work since that time. Her back condition prevents her from bending and causes her right leg to give way. She can stiffen up all of a sudden and needs help doing minimal shopping. Her back is stiff in the morning for approximately 2 hours before she can begin to walk around.

In January, 1973, [Ms. L.] suffered an acute myocardial infarction. She now has chest distress on mild to moderate exertion, recurrent palpitations related to emotional stress and, shortness of breath and exhaustion.

Recently, she has developed cervical radiculitis causing severe neck and left shoulder pain. She has also recently started seeing a psychiatrist for the emotional tension.

[Ms. L.] tells me that she was originally sent to a consultative examiner who is an arthritis specialist, a condition which she does not have. She was then sent to a respiratory doctor whom she feels pressed her beyond her physical capacity.

[Ms. L.] began receiving disability benefits in September, 1975 and was terminated in July, 1981. She was deprived of her benefit income until a request for reconsideration was rendered in our favor in March, 1982.

[Ms. R.] is 39 years old. In February, 1972, [Ms. R.] was involved in an automobile accident which resulted in a comatose condition and hospitalization for a full month. Since that time, she has had a left visual field defect involving both eyes such that she cannot see anything on her left side. She also has severe problems in depth perception. She has bumped into objects many times since she could not see them as they were on her left. She is generally house confined for fear of her safety out in the streets. She also tends to get dizzy when she walks.

[Ms. R.] memory is also very poor. A person can ask her to do something and, no sooner do they ask then she forgets. She will continually miss appointments she has made. This has caused an anxiety condition whereby [Ms. R.] is often very nervous and finds it difficult to get along with other people.

Although I am not positive, it appears from the Social Security reconsideration notice, there was no medical evidence upon which the termination was based. Rather, the denial on reconsideration was based on a report of a consultative examiner conducted well after the termination. We are now requesting a hearing before an Administrative Law Judge. It has been established by both her treating physician over the years as well as a vocational expert that [Ms. R.] is in no way able to engage in substantial gainful activity.

[Mr. McG.] has received Social Security disability benefits for 5 years but was terminated in August, 1981 after two consultative physicians examined him. [Mr. McG.] is 43 years old and has spent much time in and out of various hospitals for his paranoid schizophrenia. He was first seen by his current treating physician in November, 1963 at St. Elizabeth's Hospital. He has gone through a number of electric shock treatments over the years. He has been on numerous medications and his attempts at working in the labor market have utterly failed due to his schizophrenia. His treating physician states that his condition has not changed over the years. One consultative examiner described [Mr. McG.] as "suffering from a chronic schizophrenic illness for the past 18 years or more ... at the present time this man appears to be vegetating and is fearful of making an effort to go back to work. ... The prognosis for further change is poor." The same doctor described his ability to respond to ordinary work pressure, to work without direction or assistance, or to work around machinery as poor.

Another consultative examiner, who examined the claimant after his termination, stated that "he is a rather brittle individual and perhaps would find a heightened degree of interpersonal interaction rather provocative of anxiety and perhaps some increase in suspiciousness. He has function in a very regressed limited level and I would wonder if attempts to get him back into the mainstream of some activity would be appropriate at this point."

The claimant's treating physician is adamant that [Mr. McG.] is totally unable to engage in any form of substantial gainful activity and, for him to attempt to do so, would be very dangerous.

I realize each of these individuals is younger but I think that the facts clearly show the arbitrariness of the termination process. We are dealing here with a situation in which even a spectulative medical report such as the last one on [Mr. McG.] indicating some possibility of "entering the mainstream" should not be allowed as the basis to terminate one's benefits where such a severe psychological impairment has been long standing. In the other cases we have a stable or deteriorating condition, yet Social Security saw fit to take the person off of benefits and force her to appeal.

I will try and get you further information on each claimant, if they agree, in the near future.

Very truly yours,

Richard S. Dutka
RSD/jc

Legal Services Corporation of Alabama
Troy Office 115 West Church Street P.O. Box 228 Troy, Alabama 36081 205/566-6100 205/566-6101

December 22, 1981

Jackie Parker, Legislative Assistant
c/o Senator Levin
Room 140
Russell Building
Washington, D.C. 20510

Dear Ms. Parker:

I am enclosing information regarding a case that I think you might be interested in. I have omitted the name and address of the client because I have not received authorization from him to release this information. However, I think this is a classic example of what happens to low-income persons under the Social Security Administration.

This client received notice from the Social Security Administration dated May 8, 1981, that as of August, 1980, his disability had ended. I have enclosed this letter for your consideration. As it indicates, his benefits, monetary as well as medical, would end the last day of June, 1981. On or about June 2, 1981, he received a letter informing him that he had received $2,646.60 more in benefits than he should have and that he should refund the amount shown above within 30 days from the date of that letter. The client appealed that decision and received notice that he would be notified of the time and place of the hearing, and the case was assigned to an administrative law judge. I am also enclosing the notice of hearing that this client received. As you can see, he was charged with an overpayment of $4,938.60.

This client is a 41 year old black male. His disability stems from an accident in 1981, a heart attack in 1970, and a stroke in 1978. He has problems with his back, legs, heart and lungs. He fell 40 feet while working on a construction job. Subsequent to this, he underwent back surgery on two occasions. In 1978, he experienced a heart attack and had residual heart damage and was advised by his personal physician to avoid strenuous exercise. In 1978, he had a stroke and was hospitalized at the University of Alabama in Birmingham. The residuals of this stroke includes some difficulty with the use of his right hand. He has a 3rd grade education and was enrolled in the Vocational Rehabilitation Program. The Vocational Rehabilitation Director arranged a consultative exam for this client. It was the opinion of this physician that the client suffered from the following:

> "1. Ischemic heart disease - history of anteriolateral myocardial infarction with normal coronary arteries on cardiac catheterization - recurrent chest pain.
> 2. Chronic back pain - status post trauma and surgery on two occasions
> 3. Obesity
> 4. History of pulmonary emboli
> 5. History of middle cerebral artery embolus from mural thrombus in 1979
> 6. History of hypertension
> 7. Chronic anxiety"

In his prognosis, the doctor said the following:

> "Mr. [XX] has multiple medical problems. His problems are complicated by the fact that he has a lot of chronic anxiety and has been felt in the past to have some non-cardiac chest pain related to episodes of anxiety. In his eyes, chronic pain in spite of two back operations has been his most limiting factor. According to chest discomfort, he would be in American Heart Association Functional Class III. Because of all these problems, I think that it is unlikely that he can be retained successfully to return to the work force."

This client has two children and a wife at home. The only income this family had since May of 1981 is from the care of foster children. This amount varies each month because the number of foster children in the home varies. They experience several financial difficulties as a result.

I represented this client at a hearing on December 16 before Administrative Law Judge Moses Thompson. After taking into consideration the client's testimony and the medical evidence I submitted, the judge ruled that this client continues to be disabled and therefore is entitled to continued benefits.

This is, again, a classic example of what happens when persons are terminated from the SSI or the Social Security program. I have several others, and I am in the process of getting a release signed by the clients so that I might be able to release their names. If I may be of further help to you, feel free to call me at anytime.

Sincerely,

Janice Johnson

Janice Johnson
Paralegal

JJ/js

LEGAL AID FOUNDATION
OF LOS ANGELES

# MEMORANDUM

TO: SOCIAL SECURITY CUT OFF FILE

FROM: ELENA H. ACKEL

DATE: APRIL 15, 1982

---

[Mrs. N.] Her daughter's name is Julie. I was originally called by a [friend]

Julie isn't home during the day because she works at a rubber company and she has to call me after 5:30 in the evening that is why her friend was making the call. They have contacted their congressman who is David Dryer and they signed a release form so his office can see what is going on with her case. The victim [Mrs. N.] has lupus and gangrene on various parts of her body. On one of her toes it looks like it is dead and her right index finger. She also has gangrene on the back of her legs. She also has blood vessels in her legs that have burst. I think that she has gone to two social security doctors and both of them say she can work. In fact, she can only be on her feet ten minutes and she can't be under fluorescent lights. At the present time she is in the hospital as a result of the gangrene that she has in various parts of her body.

She got on social security disability in 1976 and they cut her off in or around 1981. Her daughter is unsure as to exactly when her check stopped and when her medicare stopped. But since her medicare stopped she hasn't been going to the doctor as frequently. She is presently in County USC and will be there three of four more days, from when I first talked to the client which means she may be in until the end of this week. The client has poor circulation in her body and she also has 35% lung capacity and 35% liver capacity. She has already lost her reconsideration and has requested a hearing. I am unsure exactly what stage she is at. She does have a lawyer.

The client has three children but they are all adults and one Julie still live in the house and is the only one that apparently has a job. The husband has only worked 21 days this year. When the client was to be cut off she begged to keep the medicare so she would have some medical insurance, but that was denied. As a result of losing the medicare she hasn't been able to go to the doctor as frequently. When she saw that her toe was turning black she thought she had hit it and broke it on something but she doesn't remember that happening. Finally the pain got to be very bad and she thought she had hit her toe. She went to the hospital and last Saturday they told her she should see her doctor the following Monday, which she did and when she was the doctor he told her she should be admitted and since she didn't have any insurance she went to the county emergency on Tuesday and she was admitted.

I was told that there was an article in the San Crabriel Tribune about a lady that was cut off of social security disability that was blind for 20 years and could only see shadows and she also had bone cancer. She was only 36 and living with her parents.

[Mrs.N.] . is in room and she is in the bed closest the door. Apparently at the time of reconsideration she was seen by another state doctor who said that she could work.

She applied for MediCal. She got an insurance payoff when her roof leaked and ruined her carpeting. She had 3000 to repair that and as a result she was denied Medical.

When the client was on social security disability, she was getting approximately $500.00 a month and Medicare.The client is only about 40 years old. The daughter Julie is very upset about this whole thing.

The gangrene growth is in several places. She is having difficulty lately because everything she touches or bumps a blood vessel burst. When she visited the ER first, about her toe, was Saturday April 3, 1982 and she was in a lot of pain and she was staying on the couch and she even went to bed on the couch because she didn't want to move. She went to the doctor because she didn't want to be in the hospital. Her own doctor is Dr. Westermeyer and he wanted her in the hospital because her lupus had flared up and apparently her condition has been bad for the last couple of months. Tuesday she went the emergency room at county USC medical center, and from Saturday to Tuesday the gangrene had set in. She went to the first emergency room on the third, her own doctor on the 5th and was admitted through the county emergency room on the 6th. At the time she went to county USC her gangrene had set in on her index finger of the left hand.

I asked if the gangrene was related to the lupus and they said she had vascular lupus and that it impeded her circulation in her feet, toes, hands and her skin is dying, so consequently they think it has something to do with the lupus. Her doctor at county USC is Dr. Fick. They also have a doctor whose name startes with M. Presently she has gangrene up the back of both of her legs. They didn't know what it was because they said her skin is always in bad condition. The toe condition she has had about a week and a half. It looks like the toe is dead. The daughter asked whether the gangrene had pentrated her legs and was she in danger or losing her legs and they said they don't think she should be but they don't know.

The daughter is very upset about the whole thing. She said her mother has been too tired to eat. She was too weak to eat and couldn't stand up on her feet. She knew there had to be cuts but it was ridiculous to cut people like that off. The daughter works during the day at a Mitchell Rubber Company. The mother has no phone in her room so she can't be reached. The other doctor that is treating her is Dr. Macher, that is how it sounds, we don't know how it is spelled. I told Julie that she needs to have her mother have the doctor write in the chart that they had permission to release their records to us and also the same with the doctor in Covina. She called me back and said that her mother did call her and she gave us permission and she would agree to see the newspeople. She didn't want her picture taken, but she would talk to the poeple as long as there was no more than two people coming to see her. Then after I got her permission tried to contact Dr. Rappaport, but was unable to reach him until the morning of the 14th. At that time he said he would be in the following day and he was going to go look at the chart and see how bad off the lady was and then he would get back to me.

# MEMORANDUM

TO: SOCIAL SECURITY CUT OFF FILE

FROM: ELENA H. ACKEL

DATE: APRIL 15, 1982

RE: [Mrs. N.]

---

Dr. Rappaport called me and said that he would look at the chart of [Mrs. N.] . He said that she had lupus with vasculitis. Vasculitis is an inflamation of the blood vessels. The patient also has gangrene in her left index finger and the right index finger and in her left great toe. She also has cronic heptitis probably secondary to lupus. Lupus is an auto immune disease where your antibodies attach yourself and various organs in your body. The patient is presently being given chemo-therapy to try to improve her condition, but is not improving at an acceptable rate, and will probably be in the hospital for a couple of weeks.

I asked the doctor about her general physical condition and he said that she is never going to get better, and she is never going to be able to work, and that because of this latest episode she is going to lose two fingers and a toe. I asked about the gangrene on the back of her legs, and he said he thought that was vasculitis. It was like a big rash on the back of her legs. He said that she was 40 years old and she has been treated at Loma Linda and then she has followed by a private doctor, but her condition is never going to get better. She will go into remission and then she will have a flare up and then she will get worst. She may have three of four month with no symptoms, but the severe symptoms will surface again.

LAW OFFICES OF
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CLIFFORD L. WEISBERG
ANTHONY B. MEISNER
CLIFFORD B. WALKON
MARTIN G. WALDMAN

TELEPHONE 353-4292
AREA CODE 313

December 4, 1981

Senator Carl Levin
140 Russell Senate Office Building
Washington D.C. 20510

Attn: Jackie Parker

Dear Ms. Parker:

As follow up to our phone conversation of December 1, 1981, the following are four (4) case summaries involving Claimants for Social Security Title II Disability Benefits, who were terminated under the current Bellmon amendment program:

CASE NO. 1.

This case involves a person who was initially awarded Title II disability benefits because of carcinoma of the larynx. This Claimant underwent a larynectomy and implantation of an artificial voicebox, allowing him to communicate artificially after a period of time. The Administration scheduled this Claimant for a consultative examination, and then ruled that he was no longer disabled, since he was able to communicate and make himself understood. While this matter was pending, another tumor was found in the Claimant's colon. This fact was communicated to the state agency. Through the efforts of myself and the Claimant's family, additional records were supplied to the state agency while the matter was pending at the reconsideration level. The Claimant underwent a colostomy, and the records covering the in-patient hospitalization and treatment were again furnished to the state agency. After waiting weeks and weeks for a determination, I contacted the disability examiner, who informed me that a decision could not be made with regard to this claim. The reason for that was because the tumor that was removed was not classified by the surgeon. Ultimately, the claim was denied and that fact was communicated to the Claimant while he was still hospitalized at the Veterans Administration Hospital. Further, within eight weeks after that, recurrent tumors were found in this man's mouth. His condition now met the Listings. When the file reached the Office of Hearings and Appeals, Judge O'Dowd entered a fully favorable decision, awarding him benefits without the need of a hearing. The net result was that this man and his family went without benefits for a period in excess of nine months.

CASE NO. 2

This claim is presently pending at the reconsideration level. It involves a Vietnam veteran who suffered the amputation of his left leg, above the knee, a crushing injury to his left heel, and multiple injuries to the right leg. In addition, he suffered a head wound requiring the implantation of a plate in his forehead. This Claimant was sent to a consultative examiner, who examined him on one occasion. The examination took approximately 15 minutes, and included a range of motion test for the man's remaining leg. No history was taken with regard to the stump complications that he has had, nor with the fact that he had recurrent osteomyelitis. The man's benefits and the benefits of his family were cut off and continue to be cut-off as of this time.

CASE NO. 3

This claim involves a woman who filed initially for disability benefits in April of 1980, because of a serious cardio-vascular condition. This condition required the performance of by-pass surgery, that was ultimately scheduled for November, 1980. While she was hospitalized, she received notification that her claim for disability was denied. Reconsideration was filed by her husband on her behalf. After this reconsideration was filed, the Claimant suffered a fatal myocardial infarction, while she was still in the hospital. The death certificate was taken to the Social Security office, in person, by the widower. One month later he received a notice that the claim was denied, because his wife did not meet the disability requirements of the Social Security Act. The claim was ultimately reversed, without the need of a hearing, by an Administrative Law Judge of the Office of Hearings and Appeals.

CASE NO. 4

This case involves a professional engineer who has been hospitalized at a mental institution not less than 10 times since being placed on the disability program in 1967. He received a notification that his benefits would be terminated even though he was still incarcerated in the institution. This matter is now pending at the reconsideration level and the benefits have been stopped, since the mid-summer of 1981.

The four cases mentioned above are the first ones that have come to mind in response to your inquiry. I am sure I have many others which may be of some interest to you. If you prefer, I will continue my search of my recent files to document further what I believe to be a grossly unfair and heartless method of getting people off of the disability program. The Executive Committee for the National Organization of Social Security Claimants' Representatives will be meeting in February, in Washington D.C. If we can be of any assistance to you in your research of these issues, please feel free to contact me,or our executive director, at your convenience.

We wish to express our sincere appreciation for the Senator's interest in these matters, and hope they will be properly addressed by the appropriate committees.

Very truly yours,

WEISBERG, MEISNER & WALKON, P.C.

By Cliff Weisberg
Clifford L. Weisberg

CLW/nad

Law Offices
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205 SOUTH BROADWAY, SUITE 506
LOS ANGELES, CALIFORNIA 90012

SUSAN P. FRANKEL
LOUIS I. FINKELBERG
ELLEN S. FINKELBERG

May 19, 1982

To; Jackie Parker
c/o SENATOR CARL LEVIN'S OFFICE
140 RUSSELL BLDG.
Washington, D.C. 20510

From: Ellen S. Finkelberg

RE: TERMINATION OF DISABILITY INSURANCE BENEFITS OF
[Ms. L.]

SUMMARY OF CASE

[Ms. L.] started receiving Disability Insurance Benefits and SSI when she had a nervous breakdown around March,1975. Her disability was based on severe psychiatric residuals, ongoing history of numerous suicide attempts and physical residuals from beatings she has received due to her explosive nature.

I do not have extensive medical information, but I know that if you can obtain the Social Security file, you will see that there was no reason to find this woman no longer disabled as of December, 1981.

When [Ms. L.] received notice of termination of her benefits, she took her young son to a neighbor and then proceeded to break every glass in her house and to try to take her life. Her neighbor, who is a client of mine, ran into the house and quieted [Ms. L.] down and arranged for her to contact me.

I arranged for [Ms. L.] to see a neighborhood psychiatrist, A.R. Tweed, M.D., and for her to see a consultative psychiatrist, Albert Jay Boner, M.D.. Social Security had obtained psychiatric evaluation, and Dr. Tweed sent in a report as soon as he saw [Ms. L.]. Based on Dr. Tweed's report, together with the information Social Security already had, the Administrative Law Judge reversed the termination on the record. The file was sent out for processing immediately in light of the explosive nature of this lady. I did not want any delay to go out and copy all of the other records.

Enclosed is Dr. Boner's evaluation. [Ms. L.] currently continues to have ongoing problems with exposive episodes and recently has been the victim of a serious beating.

If you have any questions regarding this case, please contact me.

Sincerely,

Ellen S. Finkelberg

5651 Hesperia Avenue
Encino, CA 91316
May 12, 1982

Senator Carl Levin
Attention Jackie Parker
Room 140, Bussell Bldg.
Washington, D.C. 20510

Dear Senator Levin:

I am one of the many individuals caught up in the Social Security cutbacks and terminations and, I must admit, terrified I'm going to be cut off. I'm educated, have good legal assistance, and have always been told what a strong and integrated person I was. Until now...that is.

A single parent raising 2 teenagers (one also disabled), I have no source of income other than the Social Security Disability Title II I receive as a result of having a work history. There are no rich parents or responsible ex-husband to fall back on. So that when I tell you that the constant attacks on Social Security that are part of the daily news have had a severe impact on me, I'm not exaggerating. I'm aware of the devastating consequences of these cuts because of my activism in the area, plus a personal experience of being medically evaluated to prove my disability. The experience and knowledge have left me fighting depression.

If Disability Evaluation and Social Security can't figure out something as common as Lupus, I'm afraid they're never going to figure out my rare bone disease.

Enclosed is my narrative of a consultative examination with a doctor I was sent to by Social Security for re-evaluation. The inferior quality of that examination is obvious. These examinations and the doctors contracted with are inexcusable and scandalous. I know many others must be suffering the same situation as I am. If sharing my case can reduce suffering for others, please do so. Included, also, is my signed release; you may use my statement in whatever way you see fit.

I hope the hearings prove beneficial. If you require any additional information you can reach me at the above address.

Sincerely,

Rae Eva Klaus

Rae Eva Klaus

*May 10, 1982*
*Rae Eva Klaus*
*5651 Hesperia Avenue*
*Encino, CA 91315*
*SOCIAL SECURITY #550-52-6503*

*I'm a 42 year old women who has Congential Epiphyseal Dysplasia Multiplex. I was not medically diagnosed as having this rare degenerative bone disorder until I was three. The disease destroys the joints of the body causing extreme pain, weakness, stiffness, and difficulty in movement, particularly walking. As for the future, that remains an uncertainty whether I'll continue to walk.*

*At the instruction of the State of California - Health and Welfare Agency, Department of Social Services - Disability Evaluation Division, I entered the office of Dr. Shirzad A. Abrams, Orthopedic Surgeon on April 28, 1982. The purpose of this appointment was to determine whether I was still disabled, irrespective of the fact that I have had seven (7) surgeries during the past 10 years, five (5) of these for total joint replacement. Interestingly, the last surgery was done in January 1982 and was to replace a hip implant done orginally in 1972.*

*Prior to arriving for my appointment, I called Dr. Abrams office to ask whether I could bring in x-rays from my own doctor as they were less then one month old and I am concerned with the amount of radiation I've been bombarded with over the years. I was told NO, the doctor needs to take his own. Since the x-rays were current, I can only conclude that Dr. Abrams considerations were financial rather than evaluative.*

*When I arrived at the doctors office I assumed that Dr. Abrams or his assistant would be taking a detailed medical history. I had, prior to arriving, prepared a typewritten list of my past surgeries, beginning in June 1972 to the present and most current surgery in January 1982. When Dr. Abrams entered the examining room I offered the surgical history to him. He was not interested in it; none the less, I handed it to him. The doctor then asked what my complaint was. I was startled as a disorder like mine cannot be reduced into a* *"what hurts you script" like a common cold. That was the extent of the case history taken by Dr. Abrams. The doctor seems to be unaware that my disease affects ALL THE JOINTS IN MY BODY accompanied by PAIN. Furthermore, I expected the evaluating doctor would have a working knowledge of my disease and prior information on my personal medical history. Neither was true. In reply to his question regarding what my complaint was, I told him pain was a way of life and that ALL my body was affected by this disease. Also, That as I got older the degerative process was occurring more frequently with major surgeries following on a yearly basis.*

*I was instructed that I had to pick a few parts of my body as he (Dr. Abrams) could not x-ray all of me. He asked me the name of my disease at this point. I'd like to suggest that a doctor who is ostensibly the EXPERT and has to ask me the name of my condition has obviously no information concerning me other than my name. When I asked him if he'd ever seen the disease before he replied, "Sure lots of times, do you think you're the only one?" This is improbable as I've been told by a number of medical sources that Epiphyseal Dysplasia Multiplex is a rare bone disease affecting a minute proportion of the population. Even as highly touted a medical institution as the Mayo Clinic thought me unusual enough to want a case history and pictures to use as part of their instructional materials used for training physicians. My own physician, Dr. Mark B. Stern, a Board Certified Orthopedic Surgeon for more than 20 years, found it necessary to do research and study the disease when I first became a patient approximately 15 years ago.*

*I question the capacity of Dr. Abrams, who knows nothing of the disease or the deteriorating process of the disability, to make a correct and informed determination. Dr. Abrams was totally unaware of the 7 surgeries that have occurred in the past 10 years nor did he want any information either from myself or my treating physician. The fact that Dr. Stern has cared for me throughout the years, knows my medical history, been my surgeon, and has knowledge about future surgeries for me and the quality of recovery/mobility, was of no interest to Dr. Abrams. Dr. Abrams, by the way, is NOT BOARD CERTIFIED, and by the appearance of his barren office has not been in practice for long.*

*RAE EVA KLAUS*

*When Dr. Abrams left the examining room to give instructions I overheard him say "x-ray the left shoulder, left hip and the knee." The assistant asked, "What knee?" "ANY KNEE" replied Dr. Abrams. The assistant laughed and said, "Well, that's easy." Obviously, what knee was x-rayed didn't matter to Dr. Abrams. Although, a competent physician would be interested in looking at the right knee (one with NO implant) to determine the severity of the degeneration in that joint, it was finally the left knee that was x-rayed. This knee is a joint replacement done in July 1980 that is now moving out of alignment, the consequences of that misalignment still unknown. The x-ray was taken in a reclining position, a position that would not show the misalignment and a position an experienced doctor would not rely on if his intent was evaluative rather than financial, as Dr. Abrams appears to be. Three x-rays were taken. The left hip, left knee (both of these are total joint replacements, the hip being done twice) and the left shoulder.*

*After the x-rays I was taken back to the examining room. Dr. Abrams came into the room and examined me with ALL MY CLOTHES ON. This examination took a total of 5 minutes and consisted of flexing my knees to my chest and then turning my knees from side to side. I'd like to know how a competent doctor who is sincerely interested in determining the facts, conducts an examination where the patient is dressed? Especially someone with an orthopedic problem that involves the entire body and who has incisions all over my body to prove it. But then Dr. Abrams never saw that because he must have some kind of divine or superhuman powers the rest of us don't have and was able to make a judgment about my condition by looking at me dressed. I was wearing jeans, an article of clothing which certainly does not allow for easy movement (even in someone with normal joints). Dr. Abrams never asked me to walk so that he might see the labored quality of my gait or extreme limp or the cane I use to assist me in walking. He never heard the cracking sound in my left hip from loose materials in that joint.*

Dr. Abrams then had me extend my left arm out and he turned it from side to side and said yes, you have limited movement in the left shoulder. He then had me hold out the right arm and again he turned it from side to side and said "ah, yes, you also have limited movement in the left shoulder from extreme arthritis." This inexperienced incompetent doctor didn't even know that the right shoulder was a total joint replacement done in August of 1979. Dr. Abrams then told me that I knew I was capable of doing something and that he was going to make that recommendation along with a suggestion that I be reviewed again in a year. How are Joints Dr. Abrams presently thinks are limited in movement after implants going to improve in a year?

If my history proves anything, it is that as time goes on the speed of the degenerative process increases and the implants that have been done breakdown and must be replaced again. And then there are all those virgin joints in various stages of degereration, like a time bomb, waiting to go off. As a point of interest, I had exactly two weeks advance notice before going into the hospital for my last surgery.

Dr. Abrams never asked about the constant pain I experience or the Codine I take to block its affects. Nor did he question the side effects of the medication on my ability to function and concentrate. The doctor did not consider the fact that additional undue stress on these implants will shorten their life and could render me a cripple unable to function at all. Any experienced doctor would also tell you of the additional risk factor each time the total joint replacement surgery is repeated. Additionally, I have very thin and brittle bones that leave little surface left for bonding of the surgerical adhesive needed for this type of surgery. These are only a few of my medical realities that Dr. Abrams was not interested in apprising himself. As a postscript, an outgrowth of Congential Epiphyseal Dysplasia Multiples , for me is, I have arthritis present in most of my joints.

And finally, I object to being evaluated and examined (5 minutes in duration) by an inexperienced, incompetent, NON Board Certified physician who has no knowledge of my disease or any desire to enlighten himself so as to make an informed opinion. These determination examinations are shameful and a real obscenity on individuals who must comply and allow these medical quacks to pass judgement of their disability. Social Security and their agents are making a mockery *of the medical profession and our treating physicians. Social Security is not even following their own regulation as to what constitutes a permanent disability.*

Rae Eva Klaus

*RAE EVA KLAUS*

*DISEASE - CONGENTIAL EPIPHYSEAL DYSPLASIA MULTIPLEX*

*Surgical history 1972 to 1982*

| | |
|---|---|
| *June 1972* | *Right Total Hip* |
| *August 1972* | *Left Total Hip* |
| *February 1976* | *Arthrotomy & meniscectomy right knee* |
| *March 1979* | *Osteotomy right tibia and fibula* |
| *August 1979* | *Right Total Shoulder* |
| *July 1980* | *Left Total Knee* |
| *January 1982* | *Revision Left Total Hip* |

*CC:*

*Senator Carl Levin*
*Washington, D.C.*

*Ramona Ripston*
*American Civil Liberties Union Southern California*

*Marilyn Holle, Esq.*
*Protection and Advocacy*

*Board of Medical Quality Assurance*
*Los Angeles, California*

*Ken Rasmussen*
*Department of Social Services*
*Disability Evaluation Division*

**GENERAL PRACTICE ASSOCIATES**
OF GENESEE COUNTY, P. C.
**BILL BERNARD, D. O.** **RON SUROWITZ, D. O.**
**KENNETH GANAPINI, D.O.** **JUDY KING COTTER, D.O.**

1044 GILBERT STREET
FLINT, MICHIGAN 48504
733-3140

April 19. 1982

Dear Ms. Parker,

Enclosed please find the reports regarding [Mr. B.] , as per our phone conversation. I do not have the consultants report on this case. Though it will be difficult, I will do my best to obtain it and send you a copy. I dictated the disability report on [Mr. B.] but have not been sent a copy. I will request a copy of that report and forward it to you. If I can be of further help, please let me know.

Sincerely,

Linda Preseau for
William Bernard, D.O.

GENERAL PRACTICE ASSOCIATES
OF GENESEE COUNTY, P.C.
1044 [illegible] STREET
FLINT, MICHIGAN 48504
733-3140

WILLIAM BERNARD, D.O.
…NALD SUROWITZ, D.O.
KENNETH GANAPINI, D.O.
JOY KING COTTER, D.O.

April 5, 1982

Social Security Administration
Department of Health and Human Services
Office of Disability Operations
Baltimore, Maryland 21241

Re: [Mr. B.]

TO WHOM IT MAY CONCERN:

It is especially tragic to write this letter to you at this time. I am referring to [Mr. B.] who lays dying in our hospital from hepatic failure. As of today he has a billirubin of 33 with declining hepatic enzymes which indicate that he hasn't got enough liver left to even support enzymes elevations. I doubt whether this letter will in any way influence you from your course since you rely on physicians who cannot recognize liver failure and total disability for information to make a decision concerning [Mr. B.] eligibility for disability payments.

[Mr. B.] when he found out that he did not qualify for disability payments and was being examined and re-examined by your physicians and by your reviewing boards, became distraught and depressed. He resumed drinking after a ten month hiatus during which time he had been doing so good. It seems that your efficiency in denying him his rightful benefits have in fact saved you a great deal of money because by the time this letter reaches you he shall be dead.

This letter is not meant to be melodramatic. It is meant to point up the fact that in your zealousness to withhold benefits, not only do you deprive many deserving people of their benefits but you put unnecessary stress on people who depend upon these benefits as their sole income. In the case of [Mr. B.], this stress caused [Mr. B.] to resume an alcoholic intake which he was able to discontinue for such a long period of time.

I would hope in the future that your social security administration will use physicians who can recognize total disability liver failure and who would contact the managing physician to get further information about the patients condition as this physician never bothered to find out what had transpired during [Mr. B.] hospitalizations, and who have the humane approach toward those people they examine so that this type of situation will not be repeated.

I hope that somehow you will at least see fit to pay Mrs. [B.] the money you owe her for all the time you've held up this disability. You can never undo the harm that you've done to this family by withholding [Mr. B.] benefits and causing the mental anguish that they have experienced.

I am sending a copy of this letter to Senator Levin, Senator Riegle and Congressman Kildee.

Sincerely yours,

William M. Bernard DO
William M. Bernard, D.O.

WMB:jg

[From the New York Times, May 9, 1982]

## FAIRNESS OF REAGAN'S CUTOFFS OF DISABILITY AID QUESTIONED

(By Robert Pear)

Washington, May 8—In the last seven months the Reagan Administration has ended disability insurance benefits for more than 106,000 families, including some who are almost certainly entitled to them, according to Federal and state officials.

Social Security officials said the accelerated review of disability cases that caused the loss of benefits was required by a 1980 law and was essential to control the growth and cost of the disability insurance program.

Critics say thousands of people have been removed from the rolls arbitrarily and illegally. Psychiatrists, lawyers, national groups representing the elderly and the disabled and even some employees of the Department of Health and Human Services charge that the Administration has been overzealous in its effort to remove ineligible people from the rolls.

The Government paid $17.3 billion in disability benefits last year to 4.5 million people: disabled workers, their spouses and their children. The average benefit for a disabled worker was $419 a month. Under a related program, Supplemental Security Income, the Government paid $5.7 billion to 2.3 million low-income people who were disabled or blind.

### QUESTIONS ON PERIODIC REVIEWS

Mental disorders account for only 11 percent of all the disabilities, but state officials throughout the country report that approximately one-third of the people losing Federal benefits have mental ailments. The American Psychiatric Association, a professional society, found that "large numbers of schizophrenics and other chronically mentally ill persons" were losing benefits.

Federal officials acknowledge that several people have committed suicide after being told that they were losing disability benefits.

Dr. Melvin Sabshin, medical director of the psychiatric association, acknowledged in a letter to Richard S. Schweiker, Secretary of Health and Human Services, that periodic review of disability cases was necessary to combat fraud and to verify that beneficiaries were still unable to work.

"However," he said, "the Administration's current approach, in an excess of fervor to reduce Federal expenditures, is contrary to both the letter and the spirit of the careful review that was mandated by Congress in the Social Security Disability Amendments of 1980."

John A. Svahn, the Commissioner of Social Security, dismissed Dr. Sabshin's criticism as a "political diatribe."

"We are not implementing this program with fervor to reduce the budget," he said in an interview. "This is a statutory requirement enacted before we took office."

In 1981, Mr. Svahn noted, the General Accounting Office, an investigative arm of Congress, estimated that the Government was paying as much as $2 billion a year in benefits to people who were not disabled.

He acknowledged that "some people who are entitled to benefits are losing their benefits," but he said he could not estimate the Government's error rate.

"In a system of this size," he said, "there are going to be mistakes, but in the main, the system is equitable."

Under Federal law, disability is defined as an "inability to engage in any substantial gainful activity." Only severely disabled people can meet the definition; partial disability, recognized in many other benefit programs, is not enough.

Under the law, Mr. Svahn said, the Government, in cutting off disability payments, is not supposed to consider whether any suitable jobs are actually available for a beneficiary.

Disability benefits account for only 8 percent of the budget of the Department of Health and Human Service, but they generate 95 percent of all the administrative appeals, far more than Medicare and the Social Security retirement program, which are much larger.

Administrative law judges employed by the Social Security Administration ruled in favor of claimants, against the Government, in 55 percent of all appeals last year, according to Louis B. Hays, Associate Commissioner of Social Security.

### STATES FORCED TO DENY CLAIMS

One of the judges, Ainsworth H. Brown of Wilkes-Barre, Pa., said Social Security officials were "forcing the state agencies to deny what were and still are meritorious disability claims."

State agencies, financed entirely by the Federal Government, make the initial determination whether a disability exists. But state officials have little discretion; they must follow Federal statutes and regulations, as well as the Social Security Administration's interpretations of those rules, which are often more restrictive.

Social Security statistics show that the Government ended disability benefits in more than 106,000 cases from last October to April. Federal officials estimated that more than 40,000 people had been removed from the rolls in the preceding five months.

New York State officials said they have ended benefits in 8,000 of the 18,000 cases for which they have completed reviews since March 1981. Federal statistics show that in the same period, the Government halted disability payments to more than 2,000 people in New Jersey and more than 1,000 in Connecticut.

When Congress established the disability program in 1956, it authorized benefits for people 50 years old and older whose disabilities were expected to be permanent. It liberalized the eligibility standards by degrees. In 1960, disabled workers of any age became eligible. In 1965, Congress eliminated the requirement for a permanent disability, saying that a worker could qualify if the disability was expected to last for one year.

### 75 PERCENT INCREASE IN BENEFICIARIES

In 1960, the disability insurance program paid $533 million in benefits to 455,000 disabled workers. By 1970, there were nearly 1.5 million workers and 1.2 million dependents receiving total benefits of $3 billion. Over the next decade, the number of beneficiaries increased 75 percent, to 4.7 million, and the total amount of benefits grew five-fold, to $15.3 billion.

In 1980, Congress amended the law to require periodic review of all disability cases, starting in January 1982. The Reagan Administration began the reviews 10 months early, in March 1981.

The Government must identify the people with "nonpermanent" disabilities and review their cases every three years. Rhoda M. Greenberg, the Social Security official in charge of disability programs, said that people with "permanent" disabilities would be reviewed every five to seven years.

Under the old law, she said, 150,000 cases would have been reviewed in the current fiscal year. Under the new law, she said, the Government will review 565,000 cases in 1982.

Local newspapers around the country have carried articles about the hardship caused by the unexpected termination of disability benefits. The White House has been acutely sensitive to such articles and has sharply criticized television coverage of two cases in particular.

### BENEFITS RESTORED IN 2 CASES

One case, presented in a CBS News documentary, involved an Ohio man with cerebral palsy. His benefits were cut off last December but restored after the program was broadcast, according to his lawyer and Federal officials.

The other case involved a sheet metal worker in Virginia who, according to President Reagan, had held a full-time job for three years while receiving disability payments. The Virginia man subsequently demonstrated that he was paralyzed on the left side of his body and could not work. Social Security officials agreed with him and reinstated his benefits in March.

Members of Congress, after receiving many complaints from constituents, have begun to investigate the termination of disability benefits. The House Select Committee on Aging plans to hold a hearing May 21, and a subcommittee of the Senate Committee on Governmental Affairs has secheduled a hearing for May 25.

Marlene M. Moleski, the acting Regional Commissioner of Social Security in Chicago, told her supervisors in January that people who appeared to be "obviously disabled, based upon observed bizarre and unusual behavior," were losing disability benefits. A majority of the decisions may be correct she said in a memorandum, but "in a very small percentage of these claims, the case adjudication guidelines are applied too stringently."

### PSYCHIATRIC PATIENTS DENIED AID

Dr. Sandor Berendi, a psychiatrist and paid counsultant for the Social Security Administration, went further, saying that a "significant number of psychiatric patients who clinically manifest an inability to engage in persistent substantial gainful activity are denied disability benefits."

Barbara B. Blum, the Commissioner of Social Services in New York State, said in an interview: "There is no question in my mind. Persons who cannot work have had their benefits terminated by our agency, working on instructions from the Social Security Administration. We were simply following the Federal guidelines."

Carol Bellamy, president of the New York City Council, said that when mentally disabled people lost Federal benefits, many turned to the "public assistance program of last resort," home relief, further increasing state and local welfare costs. Others she said, "join the tens of thousands of homeless men and women wandering the streets."

In Wisconsin, Robert C. Cohen, director of the State agency that reviews disability cases for the Federal Government, said that the current attitude toward mental disability claims was "deny, deny, deny."

Mr. Cohen said he had worked in the disability program for 17 years. In a letter to the Social Security Administration at the end of last year, he said that the application of the new Federal criteria was, in many instances, "ludicrous and indefensible." The standards, he said, improperly equate a "minimal ability to function" with the ability to work in a stressful, competitive environment.

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[From the New York Times, May 19, 1982]

## CUT FROM U.S. BENEFITS, DISABLED SEEK WELFARE

(By Peter Kihss)

The first people cut off from Social Security disability benefits in New York State are showing up three or four months later on home relief, a welfare program paid for only by the state and local communities.

Thirty percent—about 2,400—of 8,000 cut off so far in the state by Congressionally ordered special reviews have wound up on home relief, according to the State Department of Social Services. It estimates that eventually 40 percent may do so.

About 230,000 people have been receiving Social Security disability benefits in New York State. About the same number get disability aid in the Supplemental Security Income program.

The cuts are not part of the Reagan Administration's budget reductions. Congress in 1980 ordered reviews at least every three years to see if Social Security disability recipients might have become able to work at some jobs. The screenings, carried out by states under contract from the Social Security Administration, have been criticized as being harshly administered at a time when jobs for able-bodied people are scarce.

In Baltimore, the Social Security Administration said yesterday that 436,308 cases had been reviewed from March 1981 through April, with 174,221—40 percent—terminated. But it also said that half of those terminated had appealed to administrative law judges, and that in 67.2 percent of the appeals so far decided, the cases had been reinstated.

The Social Security disability program paid $18 billion last year to 4.6 million disabled workers, their spouses and their children, while 2.3 million other disabled workers received $4.1 billion in Supplemental Security Income benefits for the poor.

The agency said a new pilot study indicated $1 billion in Social Security disability overpayments in the July-August-September quarter of 1980, for an annual overpayment rate of $4 billion. It attributed half of this to recipient failure to report improvement in conditions or a return to work.

The Reagan Administration; the New York State Social Services Commissioner, Barbara B. Blum; the City Council President, Carol Bellamy, and Representative J. J. Pickle of Texas, chairman of the House Social Security Subcommittee, are all are moving to improve the procedures.

Nationwide, the Federal Government has ended disability insurance benefits for more than 106,000 families in the last seven months. The Government paid $17.3 billion in disability benefits last year to 4.5 million people—disabled workers, their spouses and their children. People who were disabled or blind received a total of $5.7 billion in benefits under the Supplemental Security Income program.

With the first 18,000 cases reviewed in New York being federally referred as most likely to be ineligible, the state's termination rate so far has been 44 percent. The Social Security Administration expects a final rate of 20 to 25 percent.

The state says a sampling of 450 terminations at random indicates 42 percent had mental troubles; 32 percent, muscular-skeletal disabilities; 16 percent, cardiac-vascular problems, and 7 percent, neurological disorders. It says initial screening costs an average of $300.

At least two suicides in upstate Troy have followed terminations for people with a history of mental illness, according to Christopher Burke, program administrator of the multiservice Unity House there.

One, he said, was a depressed woman. The other was a man in the Supplemental Security Income program for the poor.

### LONGSHOREMAN'S CASE CITED

Miss Bellamy's counsel on disability issues, Cindy Friedmutter, is following the appeal of a former longshoreman in Brooklyn whose Social Security disability benefits started in 1978 after a heart attack.

Last December he was ordered to take a treadmill stress test at a clinic contracted by the state. He said his union clinci and a university medical center had held that the strain of the test had caused new damage to his heart, and that he underwent double-by-pass surgery March 31. He said he was terminated in February despite the scheduled surgery.

The state estimates that less than 10 percent of cases terminated get reinstated. Of 8,000 cut off, one-third have applied for reconsideration after initial notification, and of those, 12 percent got termination notices canceled, according to Terry McGrath, a department spokesman.

Of those losing out at reconsideration, one-third have asked for hearings before an administrative law judge appointed by the Social Security Administration. Of these about half win reinstatement, Mr. McGrath said.

Miss Bellamy contends that many of the disabled, especially those with mental problems, have lacked adequate representation. Federal law makes the beneficiary responsible for submitting evidence required in a review.

Margaret Flanagan-Barrett, a client advocate for the Mental Health Association of Buffalo and Erie County, has appealed 70 cases of disability terminations or rejected applications under Social Security or Supplemental Security income since May 1971. She says 60 won favorable decisions.

Mrs. Flanagan-Barrett favors eliminating the reconsideration step, which she says can take two to six months. During that time, some claimants drop out of treatment of counseling.

A judge may take up to three months to make a decision, and three more months may pass before benefits resume, she says.

One man waiting for reconsideration, she says, was arrested for trespassing in a state psychiatric center while seeking help, and was jailed for two and a half weeks. Another was evicted from federally subsidized housing after becoming disturbed. He is now hospitalized.

### GETS RETROACTIVE BENEFITS

A man with a phobia about open places had not left his home for two years. Mrs. Flanagan-Barrett says he was terminated when he could not be induced to travel for screening. When a physician did see him, he was ruled to have been disabled for three years and given $20,000 retroactive benefits, she said.

Morris Ordower, regional Social Security spokesman, says the regional office and Commissioner Blum last March agreed to make a second review of all psychiatric cases before termination.

Next week, Mr. Ordower says, the regional office will start a review of the state's actions in a sampling of pre-termination cases.

Lewis Golinker, of New York Lawyers for the Public Interest, has a class-action suit pending in Federal District Court in Buffalo with Neighborhood Legal Services of Buffalo. The suit contends that clients have often been terminated arbitrarily, and seeks to have standards set that would require a showing of medical improvement to be employable.

Mr. Golinker wants to ask for a ban on terminations in psychiatric cases until a treating physician is consulted, and until clients who fail to respond to initial notices are checked out at home.

Commissioner Blum has urged that the Federal Government redefine disability to take a more realistic account of employability.

Representative Pickle, chairman of the House Social Security Subcommittee, has proposed a bill to let a client continue receiving aid during the reconsideration process, subject to recovering overpayment if termination is upheld.

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[From the New York Times, May 20, 1982]

## Disability Benefit Reviews: Fairness Counts

To the Editor: Robert Pear's news story on Federal and state efforts to remove ineligible recipients from the Social Security disability insurance rolls ("Fairness of Reagan's Cutoffs of Disability Aid Questioned," May 9) missed the entire point of that effort. Moreover, the story—from its headline to its bottom-line conclusions and implications—ignored or confused a great many central facts and issues.

Some examples:

The headline. It is not "Reagan's Cutoff," it is a Congressionally mandated crackdown on ineligiblity which the General Accounting Office, Congresss's own audit agency, tells us is draining more than $2 billion yearly from the nearly bankrupt Social Security trust funds.

Those funds are now running at a deficit which is mounting at the incredible rate of $17,000 per minute—with at least $3,800 per minute of that red ink, or 22 percent of the total, flowing to ineligible persons on the disability rolls, according to the G.A.O.

The article noted that this Administration began the Congressionally mandated intensive review of these cases "10 months early"—ignoring the highly relevant fact that we began the reviews at that time at the direct urging of the G.A.O.

The article clearly implied that two recipients originally removed from the rolls by their state agencies were reinstated only after intense press interest in their cases. They were reinstated after routine appeals already under way before any press attention—in effect proving that the system can and does adequately safeguard individuals' rights.

Mr. Pear quoted—without comment or rebuttal—an administrative law judge's accusation that this Administration is "forcing" state agencies to deny legitimate disability insurance claims. That statement is patently untrue.

Most importantly, the article ignored this Administration's public support for legislation significantly reforming the disability insurance review process.

This legislation, which is now pending before the House Ways and Means Committee and has broad bipartisan support, reflects Congress's own concern with longtime deficiences and anomalites in the program. It would materially ease the transition for ineligible persons from dependency to self-sufficiency.

The article also ignored administrative reforms we have implemented or planned, many of which have been widely reported in the press, to ensure that any and all reviews of disability cases are full, fair and protective of the rights of individuals.

There is ample room for legitimate criticism of this program and of Federal and state efforts to comply with the 1980 Congressional mandate that it be cleaned up within three years. Yes, there have been and will be mistakes made in individual cases. That is regrettably inevitable in any program affecting millions of individuals.

But, no, any pattern of such mistakes will not be tolerated by this Administration or by the Congress. Neither is out to deny benefits to those rightfully entitled to them. Both are out to ensure exactly the opposite—for the sake of the integrity of the disability insurance program and the solvency of the Social Security trust funds.

John A. Svahn,
*Commissioner of Social Security.*

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[From the New York Times, May 20, 1982]

## Cutoffs' Victims

To the Editor: Robert Pear's news story presents a thorough and balanced view of the nationwide cutback facing recipients of Social Security disability insurance benefits.

Mr. Pear cited a full spectrum of viewpoints—of psychiatrists, lawyers, organizations representing the elderly and disabled, employees of state agencies, employees of the Department of Health and Human Services and Administration officials. Groups that often disagree concurred in their statements that people who are obviously disabled and who cannot work are nonetheless having their disability benefits terminated. The only dissenting voice was that of Reagan appointee John A. Svahn, Commissioner of Social Security.

Mr. Svahn subsequently questioned the accuracy of Mr. Pear's article in a letter addressed to The Times, a letter he circulated widely to members of the Congress this past week. In it, he suggested that the article focused on a handful of isolated "mistakes made in individual cases." But the facts support the news story.

I have received hundreds of phone calls and letters from disabled persons and their families, treatment professionals and lawyers all across the country, describing people with severe mental and physical disabilities who have summarily lost crucial disability benefits. Legal services offices and Congressmen's offices have been similarly flooded with truly disabled clients who have been dropped from the disability rolls.

As a member of a nonprofit organization representing disabled persons, I agree with the need for periodic review to confirm that recipients continue to meet eligibility requirements and remain unable to work. However, the Administration's cutbacks have left thousands of severely disabled Americans without any source of income for food, housing and medical care.

Many have been relegated to the wards of public mental institutions or to dependency on state and county relief rolls. Others, as illustrated by Judith Cummings' May 3 news article, "Increase in Homeless People Tests U.S. Cities' Will to Cope," have ended up among the homeless. The number of suicides attributable to loss of disability benefits is steadily mounting.

The Administration's wholesale cutoff of insurance benefits that are essential to the survival of one of the most helpless and vulnerable groups in the country is contrary to both the letter and the spirit of the law. It must stop.

JANE BLOOM YOHALEM,
*Staff Attorney, Mental Health Law Project.*

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[From the New York Times, June 14, 1982]

## CUT DISABILITY WITH CARE

A commendable effort to eliminate cheating and waste from the Federal disability program has been pursued with cruel—and avoidable—zeal. Congress needs encouragement to slow down the pace and make it more humane.

Nearly five million Americans get Federal disability checks, averaging $419 a month per family. The number of recipients rose in a decade by 75 percent; the program's cost has shot up five-fold, to $15 billion. Alarmed, Congress ordered the Social Security Administration in 1980 to recertify all beneficiaries, a procedure the Reagan Administration enthusiastically enforces. Beneficiaries are even to be asked to open their tax returns.

A review is surely needed. The General Accounting Office last year estimated unnecessary payments of $2 billion annually. Periodic recertification can provide a reasonable check—if it is done in a constructive spirit. But so far, a stringent law and zealous enforcement have imposed terrible hardships on thousands of worthy beneficiaries. Many have had to scrounge for legal help to challenge cutoffs; more than half of those who have challenged them have in fact been restored by administrative law judges.

Wisely, the House Ways and Means Committee thinks the recertification can be more compassionate. It recently approved amendments, endorsed by the Reagan Administration, to let challenged payments continue until formal hearings are concluded. It would extend severance payments from three months to seven.

Congress should also help assure that state agencies are adequately staffed for the reviews. The mandate to ferret out fraud should not end up punishing the needy.

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[From the New York Times, July 1, 1982]

## LETTER: ON DISABILITY BENEFITS—PASSING THE BUCK ON TERMINATIONS

To the Editor: As your editorial "Cut Disability With Care" [June 14] correctly points out, the Social Security Administration, under the guise of eliminating waste and fraud, has unfairly terminated tens of thousands of deserving beneficiaries from what is often their only source of financial support.

You suggest this program can be alleviated by enacting H.R. 6181, a bill recently reported out of the House Ways and Means Committee. While it would cushion the blow when benefits are cut off, it fails to prevent unjust terminations.

In a staff report "Passing the Buck: Federal Efforts to Abandon the Mentally Ill" (January 1981), my office confirmed that benefits to many vulnerable, mentally disabled people are being cut because they lack the ability to represent their own interests in dealing with the bureaucracy.

Follow-up investigations of complaints from other physically and mentally impaired beneficiaries who are threatened with cutoffs revealed that people too sick to work are being reclassified as "employable" and terminated from Social Security.

When termination occurs, the only recourse is the appeals process. Federal statistics underscore the need for a fair hearing: more than half who appealed their terminations have had benefits restored.

H.R. 6181 will undermine this crucial process. Two provisions are particularly troubling: one would bar submission of additional evidence documenting disability; the other would require review judges to follow unpublished eligibility guidelines not subject to public scrutiny or review by independent medical professionals, rather than Federal legal standards.

The Federal Government plans to review the eligibility of all 160,000 disability beneficiaries in New York City. At present rates of termination, almost half—including many chronic mental patients—will be dropped from the program. Few, in fact, will rejoin the work force. Instead, most will turn to the city and state for public assistance, at an estimated city cost of $2 million in 1982 alone, and expenditures will continue to rise as cutoffs accelerate. Others—not knowing where to turn—will join the city's burgeoning homeless population.

I do not question maintaining strict procedures so that only the needy get benefits, nor do I quarrel with the intent of H.R. 6181 to being more equity to this process. Unfortunately, in its present form, the House response to the S.S.A. initiative is woefully inadequate. Unless amended, people will suffer, and all Washington will have accomplished is to shift a fiscal burden to state and local governments without providing any Federal resources. Is this what is meant by the new federalism?

CAROL BELLAMY,
*President of The City Council.*

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[From the New York Times, July 7, 1982]

## SOCIAL SECURITY LEGISLATION LIMITS DUE PROCESS IN DISABILITY CASES

To the Editor: I reviewed with interest letters from the Commissioner of Social Security and Jane B. Yohalem [May 20] on Social Security disability terminations. Commissioner Svahn alleges that proposed legislation now before Congress (H.R. 5700) is designed to insure that all reviews of disability cases protect individual rights. I have practiced Social Security law for six years; I disagree with Mr. Svahn.

The bill significantly limits due process. It provides for a "face-to-face" confrontation with the state agency on a disability termination but fails to answer many critical questions, such as: Who will hold the hearings? What training will the agency personnel have? What due process rights will be afforded the claimant? How will the hearings be scheduled? Will the claimant have a right to counsel, subpoena, cross-examination? What impact will this procedure have on the state agencies that decide initial and reconsidered disability claims and also adjudicate the termination procedures? Can they handle it?

Secondly, the proposed legislation seeks to severely limit an individual's ability to produce evidence by closing the evidentiary record after the reconsidered determination, thus depriving him of a meaningful hearing before an administrative law judge.

Other recent internal procedural changes by the Social Security Administration have severely compromised a claimant's ability to obtain counsel on a contingency basis. Statistically, represented claimants fare far better than nonrepresented claimants.

The bulk of nonrepresented claimants were usually those claiming only S.S.I. (Supplemental Security Income) because the S.S.I. provisions did not allow for the withholding and payment of attorneys' fees.

Social Security now computes S.S.I. benefits first and deducts them from the amount of Title II benefits payable retroactively, thus making it economically unfeasible for attorneys to represent claimants with concurrent claims because fees are drastically reduced.

Yet the greater impact is upon state treasuries. Supplemental benefits are partly payable through state funds. Where an individual is entitled to S.S.I he may also receive Medicaid. Federally funded Medicare entitlement is under Title II; Medicaid uses state funds. The Social Security Administration thus places what has traditionally been a Federal burden covered by F.I.C.A. onto the states.

Mr. Svahn contends that some of the termination cases highlighted in the press are isolated instances of "mistakes." I submit that attorney Jane Yohalem's view is more accurate.

Benefits are being terminated based upon evaluations completed by non-examining review physicians. I have seen cases where, despite the fact that the individual met the criteria by which disabilities are established, review doctors have found physical capacities consistent with light or medium work. Benefits are thus terminated. The physician's assessment is given probative weight through all levels of adjudication.

No realistic individual believes beneficiaries should not be reviewed. However, one must seriously question whether according to present thinking the Social Security Administration is, indeed, consciously proposing legislation that would deny benefits to those entitled to them.

VICTOR FUSCO,
*President, New York Social Security Bar Association*

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[From the Washington Post, Sept. 2, 1981]

## BUREAUCRATIC NIGHTMARE FOR THE DISABLED

(By Jack Anderson)

Although this is the International Year of the Disabled, in the United States, it's bad year for the disabled.

The Reagan administration is tightening up the eligibility requirements for those who seek disability payments from the government. This has created a bureaucratic nightmare for many legitimate recipients trying to collect the money they keeps them alive.

I don't quarrel with President Reagan's intentions. I have been far ahead of him in exposing the cheaters who draw disability benefits they don't deserve. I also applaud the president's efforts to curtail reckless government spending.

But Reagan's money managers have been scrutinizing the federal budget with eyes as cold as the marble around them. They should not lose sight of the human toll that their budget cuts can exact.

Tales of tragedy have reached my office from all sections of the country. Some people even committed suicide when they fell through the president's "safety net" and had their disability checks cut off. I have published a few of their stories. Here's another:

It concerns Helen Mary Carlton, a 54-year-old Detroit woman who was denied government disability benefits even though she had undergone a triple-bypass heart operation. According to her husband's attorney, Clifford Weisberg, Mrs. Carlton was denied the benefits because "she didn't meet the proper requirements" as laid down by the federal bureaucracy.

The reason Weisberg now represents her husband is that Mrs. Carlton died of her disability shortly after she had appealed for reconsideration of her disability claim. Incredibly, even when presented with the woman's death certificate, Social Security officials still refused to acknowledge that she had been disabled. Her family eventually was granted survivor benefits, but never got the disability payments for which she had applied.

"That was one of the strangest cases I ever came across," Weisberg told my reporters Vivian Marino and Indy Badhwar. "They didn't believe the poor woman was disabled even after she was dead."

Weisberg entered the case after Mrs. Carlton died. She might have had a better chance to collect on her disability claim if she had hired an attorney to start with; perhaps for this reason, Social Security officials do not encourage claimants to retain counsel.

"Many people are made to feel like criminals if they have to have an attorney," said Phoenix attorney Richard Gibson.

There is also the expense factor. Appealing a decision of the Social Security bureaucrats can cost $300 to $500 or more. Some attorneys take cases on a contingency fee basis, taking about 25 percent of a claimants yearly benefits if he or she wins.

Even with a knowledgable attorney, disability claimants often find it hard to obtain the medical evidence that could support their claim. Rarely do patients see the same doctor regularly at a public health facility, where many claimants are examined.

"A physician will continue to see one patient only if he or she has a strange, exotic disease," Gibson explained. It's hard for a claimant to get substantiation of a disabling condition from a doctor who may have spent only a few minutes with the patient.

Ironically, red tape sometimes works in a claimant's favor. Administrative law judges who decide on claimants' appeals must prepare a seven- or eight-page opinion explaining why they have decided to deny a particular claimant's petition. But if they accept the claimant's case and approve the benefit, they need only fill out a short form.

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[From the Birmingham News, Tuesday, Jan. 26, 1982]

## DISABLED HUSBAND'S BENEFITS TERMINATED, WIFE GOES INTO BATTLE

(By Ingrid Kindred)

A Bessemer woman who says "a newborn baby could work if my husband could work," Monday took her disabled spouse to the Bessemer Social Security office to fight cancellation of his disability payments.

And a Social Security official said he thinks the family's benefits will be restored.

Mrs. Barbara Henderson said a letter came to her home last Friday from the Social Security Administration in Baltimore, stating a determination had been made that her husband was able to work as of last December.

But 43-year-old Frederick Lee Henderson has been unable to care for himself since he came out of a nine-month-long coma, following an accident in 1975, when the car in which he was riding was hit by a train.

Mrs. Henderson, of 301 Eastern Valley Road, said the letter "was uncalled for" and has upset her family.

She said the Social Security disability check is her family's only income. The Hendersons have a 19-year-old daughter. Mrs. Henderson said her job is to stay home and take care of her husband.

So, Monday, Mrs. Henderson took her wheelchair-bound husband to the Bessemer Social Security office, so officials there could see him and realize that an obvious mistake has been made.

"My husband's been like a newborn baby since the accident," said Mrs. Henderson.

She said he is unable to care for himself, and has to be bathed and fed.

Dr. H. E. Logue, a psychiatrist who has treated Henderson for several years, said Henderson is "pretty much totally bed-ridden. He's not able to get up and about on his own. He's depressed and has a lot of anxiety."

Logue said in his opinion, Henderson suffered permanent brain damage following his accident. "His wife patiently nurtured him back to life," said Logue.

Before his accident, Henderson worked as a self-employed land surveyor. Now, said Mrs. Henderson, the family is dependent on the disability check.

"We don't have disability insurance or anything," she said.

Logue said barring a miracle, Henderson never will be able to take care of himself, nor hold a job and earn a living.

Charles Simon, manager of the Bessemer, Social Security office, said steps already are being taken to correct Henderson's problem.

"Mrs. Henderson has initiated the actions we would take to correct the situation," said Simon. "Unfortumately, when you're dealing with several million cases throughout the whole United States, there will be a few situations (like Henderson's) that develop. We don't find it a situation that we can't easily remedy. It is a thing that we can routinely correct. We don't anticipate any problems with it at all."

Simon said the SSA now is reviewing all disability benefit claims, as part of its review of overall costs of the Social Security program.

He said overall efficiency in the Social Security program "is tremendously high," however, there are some foul-ups, as apparently was the case with Henderson's termination letter.

Disability cases in Alabama normally are reviewed by the state's Disability Determination Unit, which makes recommendations to the SSA's Office of Disability Operations in Baltimore.

Decisions regarding individual claims are not made by local Social Security offices. Simon said the Bessemer office was "just as surprised" about the termination letter as Mrs. Henderson was, when she came into the office and brought her husband.

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[From the Louisville Times, Tuesday, Jan. 5, 1982]

## HIS CANCER WAS CONTROLLED?

### REVIEWS OF DISABILITY AID ARE DRAWING CRITICISM

(By Lonnie Rosenwald)

Frankfort, Ky.—For five years, Elmer Fisher has suffered from cancer that causes pain up and down his left side.

In April 1980, after 25 months of trying to convince officials of his medical problems, the 53-year-old former bricklayer qualified for $265 a month in federal disability aid.

But last September, Fisher got a letter from the Social Security Administration saying that his disease was finally "well-controlled" and that he was so much better he no longer needed his monthly checks.

Fisher said that six days after he got the letter, surgeons at University Hospital removed a malignant tumor from the left side of his neck. Today, Fisher receives regular chemotherapy treatments and his doctor says his prognosis is "very bad."

Fisher's is one of 37,600 disability cases being reviewed by the state.

The review, expected to take three years, began in March. By last month, 1,019 Kentuckians had been dropped from the disability program and state officials say they expect to cut off 11,200 more before they're finished.

The reviews were ordered by Congress after it concluded that $2 billion in disability payments last year went to people who shouldn't have gotten them.

Officials say the reviews are saving money, but they also acknowledge that the review program is the target of criticism:

William C. Evans, director of the state Disability Determinations Unit and the man charged with running Kentucky's review, says the difficulties in the review spotlight some fundamental problems in the whole disability system including requirements so strict that "you almost have to be dead to get to get disability."

Evans also says he's discouraged by the lack of personal contact between his disability examiners and claimants, which he says allows health problems to be overlooked.

As he put it, "We only handle the paper here, and if it's not brought out in the medical report, we may not have any way of knowing it."

Fewer than half of the recipients cut from the program stay off the disability rolls. The Social Security Administration's Bureau of Hearings and Appeals predicts that its appeals judges, who can consider must more subjective evidence than state examiners, will restore benefits in six out of every 10 cases that are appealed.

Some attorneys representing people threatened with losing their benefits say the review is so hasty that its tossing out the wrong people. Two months ago, for example, a Lexington administrative judge threw out a report by a consulting physician used by the state, ruling that the doctor hadn't done all the examinations described in his report.

The attorneys say many people who are cut from the disability rolls can't find work because they are too old or because employers don't want to hire someone who has been on disability. Some are forced to turn to other government programs for help.

"Once the doctor puts you on disability Social Security for six to 10 years, and then they come along, evaluate you and take you off, that finshes you," said state Sen. Bill "Fibber" McGee, D-Central Jefferson, who says he has been hearing complaints about the review from constituents.

"Nobody would want me because I've been on disability," said a 51-year-old Louisville woman who was on disability for seven years because of epilepsy and phlebitis before being cut off. Her attorney asked that she not be named because she is appealing the decision.

"If I really could work, they'd want somebody younger," she said.

Some former aid recipients, like 61-year-old Arnold Campbell of Clayhole, Ky., may simply go from disability to other avenues of federal aid, Campbell, who suffers from lung disease, back pain and deafness, qualified for $183 a month worth of food stamps after he lost his disability benefits.

Several attorneys working with disability recipients and applicants also criticize the state's use of consulting physicians—doctors hired to examine disability applicants.

Nationally, Social Security spent about $145 million for consultants in 1981. In Kentucky, consultants are called in on one of every three claims.

State officials say consultants provide the most objective—and sometimes the only—health information a disability examiner and staff physician have to go on. But critics content that some consultants provide incomplete reports based on hasty exams.

"I'll find them inadequate because they have failed to X-ray a point where a patients has complained of pain and there's a history of arthritis, they fail to put a test in writing and just put an opinion on the report," said Alvin Wax, a Louisville attorney who specializes in disability.

Federal disability programs are designed to give cash benefits to former workers and poor people who are too sick or injured to perform "substantial, gainful" work. In 1980, Social Security Title II and Supplemental Security Income paid almost $20 billion to 6.6 million people.

In Kentucky, 109,302 disabled people and 48,798 of their dependents draw $35 million a month from disability programs.

Attorneys handling appeals by those who lost their benefits say what happened to Elmer Fisher is not uncommon.

"Generally it's being done so fast that a lost of people are getting terminated who are not the kind of people who are able to work," said Rich McHugh, a Legal Aid Society attorney in Louisville.

Fisher, who still gets his checks pending appeal, said his ailment should have been obvious to any one who bothered to examine him, listen to him or check his records. He said the people who handled his case "just had it set in there mind that I would be cured."

According to Fisher's files at the Social Security Administration, the state paid a Louisville doctor to examine Fisher. She studied his 1980 medical records and X-rayed his lungs and knee, but not his neck. Her four-page report discussed his history of cancer, but concluded there was no active disease.

Records show that state disability examiner Milly Berry relied on the doctor's report plus hospital records when she recommended that Fisher be dropped from the rolls.

Later, Dr. Yusuf Deshmukh of University Hospital contacted Berry, told her about Fisher's operation and said his "lymphoma condition is in relapse and he is much worse."

Ms. Berry tried to call back the case for further investigation, but Fisher was already in line for an appeal hearing. Becky Jackson, a Legal Aid Society paralegal who represents Fisher, said the appeal process could take four months.

The Louisville doctor who examined Fisher for the state, meanwhile, insists that "there was no evidence of any kind of cancer activity" when she examined Fisher.

Because of the high rate of successful appeals, Fisher has a better than even chance of getting back into the program, and that illustrates another problem with the review.

Evans says the high rate of successful appeals renders much of his staff's work futile. He argues "either we need to liberalize the regulations so the law judges are doing the same thing we're doing or restrict them."

"That's what the administrators have been trying to tell Social Security, but they will not listen," he added.

He also said the federal regulations governing the review exclude 40 percent of the disabling ailments that examiners see.

"You may have some examiner who may think the person is disabled, but because of the regulations, they cannot allow them," he said.

Disability recipients who lose benefits for good often say they have difficulty finding jobs because of their age and a reluctance by businesses and insurers to gamble on them.

Some claimants say a consultant spent as little as 10 minutes with them. They say that's not enough time to evaluate their health, especially in the more subjective areas of mental ability, endurance and pain.

One example is the case of a Ewing, Ky., man whose disability classification was being reviewed by the state. He was examined by a Lexington neurologist whom Kentucky has used since 1977.

The neurologist examined the man on Aug. 21, 1980, and, in a confidential report obtained by The Times, concluded: "This patient has numerous complaints with no objective findings on physical examination, which would make me feel that hysteria is the underlying problem."

With proper treatment, "there should be really no symptoms of fatigue, especially on exertion," the neurologist said. "His numerous other symptoms of headache, difficulty with vision and memory are based on anxiety neurosis and hysteria."

The neurologist's report, along with other medical evidence, was considered by the state in its decision to terminate the benefits of the man who asked that he not be named as a condition for supplying a reporter with information about his case.

The man appealed the state's ruling to Administrative Judge Ben M. Combs, who reviewed an affidavit from the man's personal physician saying that for the past five years the man had suffered from Bartter's Syndrome, a rare kidney disease that causes muscle pain and weakness.

The pain alone was disabling, the doctor said, and treatment would be so difficult that the patient would "have to be confined like a research animal in a cage."

In his opinion, Combs called the neurologist's report "highly questionable."

"It [seems] the doctor did not examine his eyes, nose, throat, hearing, no pin prick, no flexion or bending, and of course, his only opinion was with treatment he should have no fatigue symptoms," the judge wrote.

Combs concluded that the report "is entitled to no weight at all."

Evans says there have been few problems with consultants. But State Human Resources Secretary Grady Stumbo said state recruiters have stepped up their efforts to find good doctors and have "done a much better job" than in the past.

Robert E. Waters, director of Social Security's disability programs branch for the Southeast, said the review of disability cases is accomplishing its goals, which, he stressed, were set by Congress.

Already, 10,600 people in the Southeast have been found ineligible to receive the disability payments they have been getting.

"The review, I would think, would be justified by removing any individual who is not eligible," he said.

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[From the Seattle Post-Intelligencer, Dec. 27, 1981]

## SHE'S PARTLY PARALYZED BY A BULLET . . . AND STILL CUT OFF

(By Eric Nalder and Timothy Egan)

Jenny M. Eichwald has two suggestions for sick and lame people who are dumped off the disability rolls by the Social Security Administration:

Get a lawyer and write your congressman.

"It may sound trite, but it's the only thing that makes Social Security officials squirm," she said. "Remember, you are dealing with the masters of red tape, the worst bureaucracy in the world."

Eichwald has been fighting the Social Security Administration since 1979 when she was left partially paralyzed by a gunshot wound to the head. Officials decided her injury wasn't grave enough to disable her.

The feisty woman took her case to a hearing judge last year and won. But in August, economy-minded Social Security administrators cut her off the rolls again. She has appealed again.

### SHOT DURING SPREE

Eichwald feels she is a victim of recent moves by the Reagan administration to prune back the rolls of those who receive federal disability payments.

The 36-year-old Capitol Hill woman was shot by convicted killer Donald Martin during a terrifying weekend crime spree in March, 1979. A .22 caliber bullet smashed into the right side of her head, destroying brain material.

She was rushed to Harborview Medical Center where she spent several days in intensive care. It was uncertain whether she would live.

Extensive physical therapy was necessary so she could learn again how to dress and bathe. Even today, she cannot use her left hand, suffers from fatigue and depression, and has difficulty dressing, records show.

### GOT A LAWYER

The ordeal with Social Security hasn't helped her adjust, Eichwald said. When she first telephoned officials to inquire about disability, she was told to come in for an in-person interview. At the time, she was flat on her back, wounded and frightened, in University Hospital.

"I was in the hospital, unable to move, but they wouldn't listen," she recalled. "I said, "What is this . . . ? You've had no trouble taking money out of my paycheck for 20 years."

Her first application for disability was mailed in June, 1979. In August, 1979, she got a postcard stating that she was denied benefits.

Eichwald got a lawyer.

In September, 1979, Eichwald asked for a hearing before an administrative law judge to appeal the ruling. Months went by, and no hearing was set. She wrote to a former family friend—U.S. ambassador and former U.S. Sen. Mike Mansfield. The former senator alerted his congressional friends, who put pressure on the Social Security Administration.

"Finally, I got my damned hearing," she said. That was in early spring, 1980.

### KICKED OFF THE ROLLS

Relying on physician testimony that Eichwald was, indeed, disabled, the administrative law judge ruled in her favor. Doctors testified that the bullet in Eichwald's brain might create further problems for the woman, who was already suffering from depression.

But in August, the federal governmental kicked her off the disability rolls.

In a form letter, Social Security officials told Eichwald that she should be able to get "substantially gainful employment" as a machine handler, material packager or a messenger service.

Eichwald laughed at the suggested jobs.

"I'm going to start a messenger service with James Brady (Reagan's press secretary who was shot in the head during an assassination attempt)," she said. "We'll call it Brain Damaged Messenger Service. Our motto will be, "We'll get it to you . . . maybe."

### REFUSES TO COMMENT

Social Security officials acknowledged in their letter that Eichwald can't use her hand. But after reviewing her files—without meeting her—they concluded, "You would be able to use both arms for pushing, pulling and reaching above your head. You would be able to lift up to 25 pounds frequently and occasionally carry 50 pounds."

Bonita Reister, the state official who reviewed her case, refused to comment.

Robert H. Dunn, assistant regional commissioner for Social Security, said, "We don't just arbitrarily take people off the rolls. Our mental set has always been in favor of the claimant."

Social Security Administrator John Svahn told a congressional committee recently that 30 percent of those now receiving Social Security disability payments are physically able to work and therefore will lose their benefits. Thousands of cases are being reviewed.

Before she was shot, Eichwald was a "hotshot typist" working as an administrative assistant for a public relations firm. Since then, she has tried working with two different social agencies but, she says, she had to resign from both because she couldn't handle the pressure.

"Social Security wants you to be so disabled you are non-functioning—or dead," she said. "You read in the paper about Social Security sending millions and millions of dollars to dead people? But I get nothing."

Until she was cut off, Eichwald got $400 a month along with Medicare benefits and housing assistance.

She wants it back. "I'm not asking for the money for a lifetime. I just want time to get my life together," she said.

[From the Seattle Post-Intelligencer, Sunday, Jan. 3, 1982]

## DISABILITY BENEFITS PROCESS IS UNDER FIRE

(By Eric Nalder and Timothy Egan)

An internal review of the decisions that state officials made in denying sick and lame people Social Security disability benefits has revealed that:

Decisions were sometimes based on outdated and incomplete medical reports.

Officials relied on unrealitic information about the local job market or believed, on insufficient evidence, that disabled claimants could work elsewhere.

Some disabled people whose condition remained unchanged were removed from Social Security rolls because federal regulations have changed.

The internal government memos, written by three visiting disability examiners from Oregon, were obtained last week by the Post-Intelligencer. One memo warned that some people pruned from disability rolls could successfully sue the government.

The P-I published a series of stories last week about mentally ill and physically disabled people who were denied or cut off Social Security disability benefits despite strong evidence in their favor. Among the rejects were a schizophrenic with a mental age of 10, a construction laborer who lost half of both lungs to cancer and a homebound gardener who suffers from such severe emphysema that he gets dizzy when he stands.

They are among the thousands of Americans affected by a massive nationwide effort to tighten eligibility for Social Security benefits.

In this state, Social Security officials are rejecting dozens of disabled applicants even though they have been found eligible by state health professionals who initially approved them for benefits.

The internal memos obtained by the P-I were written by Ellyn Boyer, Lloyd Horsley and William J. Rohr, three Oregon state disability examiners who work on a daily basis with the Social Security Administration. The three examiners determine who is eligible for disability benefits.

The Oregonians were asked to come to Seattle in September to review the work of their counterparts in Washington state, partly because officials here wondered why hearing judges were reversing a large number of the government decisions to deny people benefits.

The judges, to whom any rejected claimant can appeal, have reversed 74 percent of the government denials in this state this year. The Social Security Administration is so disturbed by the trend that it recently targeted four of the eight Seattle judges, and 64 of 700 nationwide, for a special review of their decision-making.

### MORE HUMANE LEVEL

The Oregon examiners found that one reason the judges were reversing so many rulings is that they use different standards than the state officials.

Boyer said she found during her stay in the Seattle regional office that the judges were treating people more humanely than the state examiners.

"We at (the state agency) often joke about claimants being allowed for hangnails, low back strain and menstrual cramps," she wrote. "But, I must admit, that after sitting in on a few hearings, I now have the opinion that the (judges) operate on somewhat of a more humane level than the (state agencies)."

The three visting examiners pointed out, however, that unlike the claimant, who was usually assisted by an attorney, no one represented Social Security at the hearings.

"I found the hearings to be a very one-sided affair," Horsley said.

### FAULT WITH EVALUATION

The examiners found that hearing judges tended to be more "realistic" about the ability of mentally retarded and crippled people to get a job in this tight market. Under federal regulations, officials can reject claimants if they think they could get a job anywhere in the U.S.

The three examiners found more serious fault with how claims for disability were evaluated.

Horsley said four of the eight Washington cases he reviewed in which claimants were denied benefits lacked good documentation and "correct" decisions.

He said one rejection was obviously wrong, another file didn't contain enought evidence for a denial, a third was sent to the wrong jurisdiction and a fourth case was decided on "quite questionable" evidence.

Examiner Rohr said he looked at a total of 60 files of people who were rejected and a "large number" contained "inadequate" and outdated "medical documentation."

Boyer complained that state examiners simply rubber-stamped cases in the government's favor when rejected claimants asked for reconsideration of a negative ruling. She said such reconsideration cases are often "affirmed as written . . . without further development (of new information)."

Mary Buskirk, chief of the disability analysis branch for the regional Social Security office, said the rubber-stamping "happens periodically with every state, but I wouldn't make it as a general statement."

Horsley complained that examiners are required to use an outdated book that lists jobs and their requirements. The voluminous job book is important because examiners must prove that an applicant is so badly disabled he couldn't find meaningful and gainful employment.

Buskirk said the new book isn't used because it contains errors, but the judges are using it in their determinations.

Boyer noted that Washington examiners rely on medical information that is in some cases eight months old.

Timothy Latta, Boyer's boss in Oregon, observed that a person's condition can deteriorate rapidly in just six month's time.

### RANKED 22D

But Ed Davis, chief of the Washington state office that evaluates disability claims, defended the use of older medical information, saying it is sometimes the best available. He disputed Boyer's claim that Oregon examiners do better evaluation work than examiners in Washington.

Oregon examiners, however, recently ranked number one in accuracy in a Social Security study. Washington examiners ranked 22d, which is above average but is is the poorest ranking in this region, according to Robert Dunn, regional commissioner for Social Security.

Despite the poor screening and paperwork on some cases, Social Security officials claim that they are simply carrying out a congressional mandate to tighten up the system.

"We aren't Scrooges and pirates," Davis said.

### UP TO STATE AGENCIES

Buskirk, who oversees examiners in four states, says state officials must follow "rather stringent guidelines."

It's up to the state agencies, like the Department of Social and Health Services in this state, to decide if people are eligible. The applicants have paid money into the Social Security fund all of their working lives, and they are entitled to disability if they meet certain written requirements.

Social Security benefits range upward from $400 a month for a single person.

In Washington, examiners have become less generous each year. Some 45 percent of applicants were approved in 1977, but the number dropped to 33 percent this year.

### MUST BE DEVASTATING

Oregon's Latta said last week that Social Security is no longer honoring an old principle that people on disability rolls can't be removed unless there is proof that their medical condition has improved.

Some people now receiving benefits might well find themselves suddenly, and with very little warning, thrown off the rolls even though they haven't gotten better, a situation that "must be devastating," Latta said.

"It seems to me that these people would have a good class action suit," Boyer commented in her memo.

After the P-I stories were published last week, dozens of people telephoned the P-I with their own stories of hassles with Social Security. Dunn said his Social Security office, too, has received calls and letters.

He said some disabled people are frightened that they, too, will be dumped from the rolls.

"All I can tell them is that during the next five years everyone who is not permanently or totally disabled is going to be reviewed," he said.

[From the Los Angeles Times, Sunday, Mar. 21, 1982]

## U.S. Crackdown Assailed—Disability Purge Ruinous to Many

(By David Treadwell and Marlene Cimons)

Washington—A 42-year-old, small-town Ohio woman—divorced and the mother of two teen-age children—suffers from severe heart and lung diseases and needs regular doses of oxygen around the clock. But last October, Social Security officials decreed she no longer was disabled and thus no longer entitled to government help.

Desperate, the woman appealed her case. Yet despite a letter from her doctor stating that "she is just barely alive, let alone able to work," she again was denied her $549 monthly benefit. Only after the commissioner of Social Security himself, John A. Svahn, read of her plight and ordered a quick review did an administrative law judge rule in the woman's favor.

The Ohio woman is one of countless Americans whose lives are being disrupted, and sometimes destroyed, as a result of a little-publicized drive by the Reagan Administration to purge ineligible beneficiaries from the rolls of the Social Security Administration's $22-billion-a-year program of disability insurance.

### 500,000 CASES REVIEWED

No one questions the need to ensure that disability payments—now going to almost 7 million Americans sidelined from work because of severe illness or injury—are made only to qualified recipients. More than 500,000 disability cases are being reviewed this year, with a termination rate of 45 percent.

But an investigation by Times reporters indicates that there are perhaps thousands of cases like the Ohio woman's—some less dramatic but no less devastating—in which beneficiaries are being cut off in the crackdown, despite clear records of long-term disability. Indeed, panic and anxiety, induced at least in part by sudden cutoffs of disability benefits, have been implicated in about a dozen suicides since the crackdown began.

And many other recipients whose cutoffs are questionable have been unable to understand or cope with the Social Security Administration's complex procedures for review of their cases. This is expecially true, social workers and others involved with the disabled say, of individuals suffering from mental illness—a large category of the system's beneficiaries.

A Times survey of hundreds of pages of documents and interviews with scores of past and present government officials, congressmen, physicians, attorneys, disability insurance experts, social workers, mental health advocates and the disabled themselves show that:

Beneficiaries have been lopped from disability rolls even though both their doctors and the Social Security Administration's own physicians agree that the individuals cannot perform even ordinary day-to-day functions of living.

### RECIPIENTS DENIED BENEFITS

Recipients have been denied benefits even though they meet the so-called listing of impairments used by Social Security to determine whether a person is capable of work.

Terminations have occurred as a result of inadequate medical or psychiatric examinations by physicians under contract to Social Security to perform consultative evaluations.

Disability payments have been canceled without up-to-date medical evidence to support the termination.

"Social Security is using seriously flawed procedures in its investigation of the continuing eligibility of current recipients of disability benefits," said Sen. Howard M. Metzenbaum (D-Ohio), who has requested a General Accounting Office investigation of the problem.

"I think what they're doing is arbitrary, capricious and illegal," said Wilbur J. Cohen, secretary of Health, Education and Welfare in the Administration of former President Lyndon B. Johnson and president of Save Our Security, a coalition of 100 national organizations. "You're dealing with sick and disabled people, some of them neurotic, some of them phychotic, some of them unemployable."

"This is really alarming," said Nancy Rosen, social worker at an Evanston, Ill., halfway house for mental patients. "We have people who have been on disability for years suddenly being reviewed and cut off. And nothing we say to justify their staying on seems to make any difference."

"I'm glad I'm getting my benefits back," the Ohio woman, whose name is protected by government privacy laws, said last week. "I couldn't have lived without it. I just really, really feel sorry for all the others who should be on disability and aren't anymore."

Administration officals are aware of the problems that have developed because of their cost-cutting drive.

In an interview with The Times, Social Security Commissioner Svahn said he is looking at possible measures to relieve some of the distress that has been caused by the Administration's poiicies. "We're very concerned about this," he said, conceding that "mistakes have been made."

### INSURERS PRAISE CRACKDOWN

However, the Administration's crackdown was praised by private disability insurers. "In the business world, this would be normal procedure," said R. C. Ellis, executive vice president of Mutual of Omaha and head of a special committee on Social Security disability for the International Claims Assn. "I have read some of the 'horror stories' in the papers—but I also know this: These people all have recourse. They can appeal."

But the complex appeals procedure can take months to run its course. Denied their disability payments in the meantime, many former recipients turn to welfare and food stamps.

In many cases, truly disabled beneficiaries taken off the rolls appear to be the victims of overzealous disability examiners. And some examiners say their decisions are more likely to be reviewed by their superiors for continuing a client than for terminating him.

"I'm not going to get paid more if I cut someone off," said Michael Lomax, president of the National Assn. of Disability Examiners and operations consultant for the Nebraska state disability determination agency. "But it does work as a subtle reminder: 'Hey, if I don't cease (terminate) this claim, it will get reviewed.' "

Other beneficiaries have found their checks cut off through an overly stringent application of the regulations governing disability. "The current adjudicative climate . . . seems to be one of deny, deny, deny," a Wisconsin state official complained in a memorandum in December to the regional Social Security office in Chicago.

And, as in any other federal program, still other beneficiaries have been eliminated because of honest mistakes or oversights on the part of adjudicators.

To be sure, thousands of unqualified beneficiaries have been taken off the roles. And even the harshest critics of the Administration's drive agree that most disability examiners and other Social Security workers approach their jobs conscientiously and in good faith.

### INFLUENCED BY POLITICS

But, as disability insurance experts point out, determining whether a person with physical or mental impairment is truly disabled—especially in borderline cases—is partly a subjective judgment. And within the Social Security system, those subjective judgments are influenced by the political climate set by the Administration.

"You can have vastly differing decisions depending on whether the climate says 'When there is reasonable doubt, deny it.' " said Sam Crouch, former disability insurance director for Social Security who played a key role in writing many of the guidelines still used in determining disability.

For whatever reasons terminations are made, the consequences—particularly for those who have little or no resources to fall back on—are often devastating. Among the examples turned up by a Times investigation:

Commer Foskey, 40, a rural Georgian with two ten-age daughters, is faced with going on welfare to survive. Foskey has had three major operations and has been in and out of hospitals 29 times by his own count as the result of a work-related injury that ruptured two discs in his back. Yet he was cut from the disability rolls in October after drawing benefits for eight years.

The decision was based on a Social Security medical review that neglected to evaluate his extreme pain or his dependency on pain-killing drugs. "They said I should get work as a gas station attendant," says Foskey, who is blind in one eye and has limited vision in the other. "I can't hardly read the gas pump."

### KIDNEY PATIENT SEEKS AID

Adeloipa Hernandez, 56, of El Monte, Calif., is threatened with a strenuous—and potentially costly—legal battle to get back on disability. In 1973, after almost two years of dialysis treatment, she underwent a kidney transplant operation.

The new organ has functioned well, but the drugs she takes to avoid rejection of the kidney produce frequent back and joint problems along with fungus and bladder infections. Yet last summer Social Security told her she was no longer disabled—despite a report by one of its own doctors that she was totally incapable of working.

Hubert Tuttle, 46, of Lansing, Mich., is one of the dozen or so reported suicides around the nation linked directly or indirectly with disability cutoffs. Tuttle, father of two college-age daughters, had been a machine shop foreman until he suffered a severe back injury.

Despite his almost constant pain, his family said, he had a cheerful personality and good humor. But when Social Security reviewed his case and ruled that he was ineligible for benefits, Tuttle drove to the agency's local office and shot himself with a 16-gauge shotgun.

"They are playing God," a note he left behind said. "I cannot live on welfare."

Administration officials now are aware of such problems and have taken at least one step to soften the impact of the stricter examination of disability cases.

Svahn, a Reagan appointee who also was among the inner circle of officials who helped design the President's overhaul of welfare when Reagan was governor of California, announced last week that he is eliminating a rule requiring back-billing of beneficiaries where a retroactive determination of medical recovery is made.

Under that rule, if a review of a beneficiary's eligibility concludes that his disability actually had ended a year ago, Social Security can bill the beneficiary for payments received since then.

"It makes little sense to decide that a person had medically recovered in the past and must repay us benefits, when the delay in our determination is the fault of the system rather than the individual," Svahn said.

The Social Security Administration actually runs two separate disability programs: Disability Insurance, which is financed through payroll taxes and pays benefits to disabled workers and their families based on the worker's past earnings, and Supplemental Security Income, which is funded by general revenues and pays benefits to low-income blind and disabled persons based on proved need.

About 2.9 million workers and 1.8 million family members get Disability Insurance benefits, with the average disabled worker receiving $413 monthly, plus $398 for a spouse and two children, according to the latest figures.

### SUPPLEMENTED BY STATES

Another 2.3 million individuals and couples receive Supplemental Security Income, with the average individual drawing $181 a month and the average couple getting $214. States sometimes supplement these federal benefits, which would raise the average benefits.

To be eligible under either program, an individual must be unable to engage in any "substantial gainful activity" by reason of a medically determinable physical or mental impairment that is expected to last at least 12 months.

The government always has performed about 150,000 to 160,000 follow-up checks each year on beneficiaries under both programs, but usually only on people who, at the time they began receiving benefits, had been expected to recover. Rhoda Greenberg, director of Social Security's Office of Disability Operations, said the termination rate in those cases generally has been more than 50 percent.

Two years ago, under the Administration of former President Jimmy Carter, Congress ordered Social Security to review the cases of people with nonpermanent disabilities at least once every three years. Those with permanent disabilities were to be re-examined every five to seven years.

Congress also called for a step-up in the number of cases to be reviewed, originally to start last January.

But shortly after Reagan took office—prompted by a General Accounting Office report that as many as 584,000 people receiving Disability Insurance benefits may not currently be disabled and may be costing the government more than $2 billion annually—the Administration moved up the timetable for beginning the review by nine months.

Following the GAO report's recommendation, Svahn also ordered the additional reviews to concentrate solely on Disability Insurance recipients, because the potential payoff from uncovering unqualified benefits was higher given the higher benefits paid under that program.

Now 360,000 cases are being reviewed annually, in addition to the regular 150,000 to 160,000 ordinarily reexamined. As a result of the accelerated review process, the Administration predicts it will save $372 million this year, $730 million in 1983 and more than $1 billion in 1986. The termination rate, now 45 percent, is expected to fall in succeeding years because most of those cases likely to be terminated will be discovered early in the crackdown.

Administration officials contend that lax management and overly generous benefits in the past have caused the disability rolls to become swollen with "welfare riders"—at a staggering cost to the nation's taxpayers.

And despite the troubles experienced in this initial phase of the speedup in reexaminations—troubles the Administration hopes to have smoothed out soon—the process generally is working well and the number of erroneous terminations is far less than critics claim, these officials say.

But the critics maintain that it is just the speedup that has led to what they consider the current crisis in Social Security disability. They contend staffs are inadequate to handle the increased volume of claims.

In Illinois, for example, the state agency that handles Social Security disability claims has only one psychiatrist on its staff of part-time doctors who have the final say-so on disability claims.

Dr. Edward Ference, chief medical examiner in the Illinois Division of Disability Adjudication Services, admitted that "by far the great majority" of review cases involve mental disabilities and that many non-psychiatric doctors are passing judgment on such cases. But, he said, "this is not a serious problem because staff physicians are well-versed and . . . get ongoing training in the psychiatric area."

A suburban Chicago psychiatrist, who has done consultative examinations for the state agency for the last 10 years, disagrees. "They're doing something medically improper," said the psychiatrist, who asked that his name not be used for fear of reprisal. "It's like me judging a surgical case. I could guess but I don't have the expertise."

### CRITICAL OF PROCESS

Robert M. Ball, commissioner of Social Security under former Presidents John F. Kennedy, Johnson and Richard M. Nixon, also is critical of the accelerated review process.

"They should have gone more slowly. There wasn't all that big a rush," Ball said. "It's terrible what they're doing. I think they're going to get reversed all over the place."

Beneficiaries terminated after a review can request consideration by the state agency if they are dissatisfied with the initial decision. If they are again denied benefits, they can appeal to an administrative law judge. Ultimately, appeals can be carried to federal court.

Records show a beneficiary who has been terminated has just about even odds of having those benefits restored if he goes to an administrative law judge.

Several of the judges have openly criticized what they describe as the dubious manner in which the review process is being made and what they consider to be flagrant errors being committed by state agencies in deciding whether beneficiaries are capable of working.

"Every judge I know has seen cases so ridiculous they shouldn't even be coming before us," said Don Edgar Burris, chief administrative law judge for Montana. "There's no way these people could be denied if the disability examiners were doing things in a conscientious manner."

On the other hand, Louis B. Hays, assistant Social Security commissioner for hearings and appeals, argued that such a high percentage of reversals is more indicative of problems in the entire adjudicative system.

### MORE UNIFORMITY URGED

Hays pointed out that, unlike state disability examiners, who simply examine records and medical findings, the judges see the claimant face to face—most likely with legal counsel—and have the benefit of additional medical evidence. Sometimes the claimant's physical or mental condition has actually worsened, too, by the time his appeal is heard, Hays said.

Administrative law judges also are not bound by the claims-manual interpretations that bind state agencies—something Hays said he would like to see changed so that the entire adjudicative process would be more uniform.

Administration officials say the eligibility standards for Social Security disability payments are strict—perhaps the strictest of all government disability programs—and their aim is to enforce them to the letter.

This posed a dilemma for a 46-year-old Korean War veteran in Los Angeles who was cut from the Social Security disability rolls about seven months ago despite being certified as incapable of working by the Veterans Administration because of manic depression.

"One side of the federal government says he's disabled and the other side says he isn't," said Tom Rossebo, who runs a facility where the veteran has lived since 1975.

Rossebo said that he has allowed the veteran to remain at the facility, despite his inability to pay since his Social Security disability benefits were terminated.

"We can't really put him out in the street," Rossebo said. "We're a large facility, 70 beds. But . . . there are a lot of places that when you can't pay the money, they just put you out."

Pressure is mounting on Capitol Hill for legislation to answer the concerns raised by the re-examination process, particularly the concerns of those beneficiaries who have been deined disability payments despite severe long-term injury or illness.

Several bills have been introduced that would require benefits to continue while claimants are appealing terminations. Other measures call for more safeguards for beneficiaries during the review process. Rep. J. J. Pickle (D-Tex.), chairman of the House Ways and Means subcommittee on Social Security, also has offered a plan designed to make the entire adjudication process more uniform.

At a recent hearing on the measure, Pickle stressed the need for the disability rolls' review, mandated two years ago by Congress.

At the same time, until this process is settled down and becomes a regular part of the proceedings so that it does not come as such a surprise to the recipients, some adjustments and special allowances are in order," he said.

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## WITNESSING THE WORST THING SOCIAL SECURITY HAS DONE

(BY MARY JANE FINE)

Thirteen years ago he served in Vietnam, and this is what he has to show for it: one leg amputated at the knee; two fingers amputated; his spleen and part of his stomach removed; his jaw wired shut; part of his buttocks shot off, and an enduring bitterness toward America, a feeling that his country didn't stand by him after he came home.

About six weeks ago, the veteran received a letter that confirmed that belief. It was from the Social Security Administration (SSA), informing him that his $400-a-month disability benefits were being cut off, Medical records indicated that he no longer was disabled and could therefore engage in "substantial gainful activity," the letter stated.

Upon receiving that letter, the veteran, a Delaware County resident, jointed thousands of Americans whose disability benefits have been canceled since the Social Security Administration, under the Reagan administration, escalated a vigorous review program aimed at cost-cutting.

"This is the worst thing Social Security has done since its beginning," said Jonathan Stein, chief of special projects for Community Legal Services (CLS) in Philadelphia. "They've run reckless with denials."

Panic-stricken at receiving the termination notices, many disabled persons have asked their state legislators to intercede on their behalf. The Vietnam veteran called the office of his congressman, Democrat Robert W. Edgar.

"We've always received calls like this but recently they've escalated," said Audrey Bardsley, an aide to Edgar who has dealt with the veteran's case and declines to identify him. "In my eight years with [Edgar], I've never seen anything quite as bad."

"We wrote a letter to Rose Lepore because we deemed this one case that couldn't be terminated," Ms. Bardsley said last week. "In my estimation, it was not a favorable response."

Ms. Lepore is the Social Security Administration's regional director for the Philadelphia area.

"Bear in mind one thing," she replied when asked about the veteran's case. "It's highly possible to have a leg amputated, part of a stomach removed, buttocks shot, and yet, by everything that's holy, look at his medical records and say he is capable of doing some sort of sedentary work. He can use his hands, maybe he'll need a wheelchair.

"I know how cruel that must sound, but that's how our rules are."

This year alone, the Social Security Administration is reviewing 550,000 disability cases nationwide, the highest number ever reviewed and a significant increase over the 150,000 annual average. About 45 percent of the cases reviewed are losing their benefits. The plan calls for the reviews to escalate to 862,000 next year.

Congress mandated the reviews in 1980 during the Carter administration after a General Accounting Office (GAO) study concluded that as many as 20 percent of all disability recipients might not be qualified. A Social Security law amendment, aimed at weeding out the unqualified, ordered case reviews every three years for most of those on the disabled roster, and every seven years for those permanently disabled.

The intent of the legislation was to reform Social Security's frequently overburdened and inefficient operations, but critics, including legislators, lawyers and social service advocates, say the review program is being used with unprecedented vigor. They lambast it as "overzealous," "callous," "arbitrary" and "capricious."

The acceleration of reviews, Stein said in a recent interview, is resulting in "an assembly line of callous and superficial decison-making" on the part of the Disability Determination Division, a state agency in Harrisburg that makes recommendations on disability cases in Pennsylvania to the Social Security Administration and sends out the termination notices.

Since July 1981 the state agency has reviewed 8,603 of Pennsylvania's 244,000 disability-insurance recipients and cut off benefits to about 2,400 of them.

The problem, Social Security administrators say, is that the rules have always been there but enforcement was lax prior to the GAO study, which concluded that paring down the rolls represented a potential savings of $2 billion.

"There's no question [that Social Security] was in some kind of shambles," said Ms. Lepore. She said that, because of the system's laxity, some people were incorrectly judged disabled or were never removed from the rolls once their temporary disability improved.

"There are people who don't fit into the disabled definition now, and somebody's got to do something about it. I really don't have an answer."

Countered Stein, "There is an attitude that unless you're completely bedridden, totally on your back and unable to move even an eyeball, you're not disabled. That is a shameful mispresentation of the law."

However the law ultimately is interpreted, the disability reviews have become the focus of increasing controversy, which one side calls scandal and the other deems a necessity. But no one disputes that they have given rise to a flood of distress stories such as the veteran's. Those that follow, selected from cases in the Philadelphia area, are representative.

Gladys Sample's first job, at age 18, on Tilghman Island, Md., was slitting open oysters with a knife. She had left school after the seventh grade. Later, she cut up fish in a cannery. After that, she worked in a factory, skinning tomatoes. Still later, she raised chickens in Delaware.

In 1964 Mrs. Sample and her husband moved to a second-floor apartment in a North Philadelphia rowhouse, and she got a job operating power machinery in a now-defunct garment factory on Market Street. The job involved piecework, which meant that the faster she produced, the more money she made. The machinery was controlled by a foot pedal, and "the harder you push, the faster the machine goes," she said.

Now Mrs. Sample is 60. Her husband died 10 years ago. She is severe diabetic and has blurred vision and pain in her legs, both complications of her disease. She went to bed one night two years ago and didn't wake up in the morning. After shouting and pounding on her door, neighbors finally had police break into the apartment about 3 p.m.; they found Mrs. Sample in a diabetic coma and rushed her to Temple Hospital.

"When I came home, I stayed up walking this floor all night long," she remembered recently. "I'd walk up and back, from this room to that, looking out this window time and again. I was afraid I was going to go to sleep and never get up."

In 1975 her illness had forced her to stop working, and the Social Security Administration determined that she was disabled. Until recently, she lived on her $355-a-month disability check.

Then a form letter arrived in December notifying her that her payments would be ended. Through her social worker, she requested reconsideration, but a second form letter in February reconfirmed the termination. Her last check arrived in January.

"I can't understand the Social Security people," said Mrs. Sample. "They were the ones put me on [disability], I don't understand why they're taking me off it. I'm a much older woman, the sugar's still in my body."

In February, to cover the $180 rent that she prides herself on paying promptly, she withdrew all the money she had in the bank, $53, and added it to a $115 emergency welfare check that the social worker helped her obtain. A neighbor lent her the balance.

Mrs. Sample is currently receiving $172 in welfare and $37 a month in food stamps. Her neighbor lends her the additional $8 for her rent. She has no money to pay her electricity, gas or telephone bills.

"In the beginning, my neighbors was giving me food," she said. "I can't just live off my neighbors and eat their food up. I got to have a telephone."

Mrs. Sample said she cannot understand how the people at Social Security can think she is capable of returning to work. She also cannot understand how money she paid into the system all her life can suddenly be revoked.

"This is my money," she said. "I'm not asking them for anything. I'm not one of those people who worked today and not tomorrow. I never missed days. Now why take that from me when I need it? I would rather be working, but, I mean, who's going to hire me, a 60-year-old woman?

On Mrs. Sample's behalf, Deborah Harris, a CLS lawyer, wrote a letter to Frank McArdle, an aide to Sen. John Heinz (R., Pa.) and the Special Committee on Aging, which has been hearing testimony recently on the Social Security cutbacks.

"SSA's action," the letter stated inpart, "is a sad commentary on our country's treatment of the elderly and disabled who have worked all of their lives. I urge your committee to recommend controls on SSA's rampage against our most needy and deserving citizens."

Hers was a limbo world: fragile, floating, filled with nameless fears. The woman tried to hold it together, but it frayed and unraveled.

Her letter from the Social Security Administration reached her in the psychiatric hospital where she was a patient. Its tone seemed mocking to her, with its claim that "based on evidence now on file, it appears that a determination would have to be made that you regained ability to engage in substantial gainful activity."

One of her doctors assured her it must be a mistake, but her disability checks ceased shortly afterward.

"I think what happened to her is an utter travesty," said Germaine Ingram, the CLS lawyer handling her appeal. "The Social Security Administration isn't concerned with compliance with the law or human suffering. They're concerned with fiscal matters at the expense of the well-being of those the system was designed to help."

Recently, the woman, a Philadelphia resident, talked about her psychiatric history, requesting anonymity so as not to hurt her chances for future employment. An unlit cigarette clutched in one hand, a lighter in the other, she talked for two hours as her two small cats stalked in and out of the room. She got them, she said, "because I read cats were good company if you're depressed. . . ."

A measure of her depression was the amount of time she would stay in bed, often all day long, rising only to use the bathroom. Unwashed clothes, empty boxes and assorted papers would pile up around her in her Northeast apartment.

Twice she attempted suicide. After the first attempt, in December 1975, the women began seeing a psychiatrist. After the second, in September 1976, she woke up in a hospital intensive-care unit, with restraints binding her arms and legs and a tube in her throat.

In 1978 she lost her job as a registered nurse at Temple University Hospital, where she had worked for five years. In 1979, unable to work, barely able to care for herself, she qualifed for $662 a month in Social Security disability insurance retroactive to 1978.

Under continual psychiatric care, she has had ups and downs. Once, after receiving electric-shock therapy, she experienced a two-week period of buoyancy during which she felt confident, assertive and happy. At other times, she suffered extreme anxiety during which sleep was difficult and food tasted "like paper."

She remembers one time, when a friend escorted here on a rare outing downtown, she stared in awe at passers-by and thought, "Lood at them: they got up this morning and they're walking and talking and they're going to their jobs. What's the matter with me?"

From March 6 to May 10 of last year, diagnosed as severely depressd, she was a patient at Fairmount Institute in Roxborough. Midway through her hospitalization there, her son, 18, brought her the termination letter from the Social Security Administration.

Separated from her husband, she currently lives alone on $172 in welfare and $87 worth of food stamps each month.

Her attorney, Ms. Ingram, said that beyond the material difficulties, she worries about the effect this latest setback is having on here client's self-esteem and ability to get well.

"Recently she said to me, 'You know, Germaine, the state should build gas chambers for people like me.' "

Joseph Borell is an affable, overweight Philadelphian with a multitude of medical problems and a penchant for making bad jokes.

Pulling his shirt up to display the rubber tubing that protrudes from his lower back, he said last week: "if somebody bumps this, I see stars . . . Lana Turner, Clark Cable, Bob Hope."

Borell's tubes are attached to his kidneys, which do not function properly. He has to be hospitalized once a month for treatment. Despite that, on March 19 he received a notice from the Social Security Administration, which said in part, "Recent blood tests show that your kidney's [sic] function normally. The remainder of your physical examination is normal. You have no impairments that would be considered disabling at this time."

The letter informed Borell that his disability payments of $493.20 a month would cease in May.

Borell requested a reconsideration, which is now being processed in the Social Security Administration's Baltimore headquarters. Jessica Marquez, a paralegal handling is case through CLS, is not optimistic.

His request will almost certainly be denied, she said.

This is Borell's third confrontation with Social Security since be became disabled in 1976, and the second time Ms. Marquez has represented him in his attempt to have his benefits restored.

On Tuesday, Borell with be 56. Over the years he has held a variety of jobs draftsman, welder, bottle washer and carpet weaver among them. He enjoyed carpet-weaving the most and speaks of his fancier designs—ocelot and leopard prints—with considerable pride.

He was working as a carpet weaver when he became ill with cancer of the bladder. Doctors at Parkview Hospital at Castor and Wyoming Avenues removed Borell's bladder, prostate, appendix, some lymph nodes and portions of his colon. They also performed an ileostomy, and since then he has had to wear a urine bag.

In subsequent hospitalizations, Borell said, he has undergone 16 other surgical procedures, including surgery for bowel obstruction, abdominal herniation, abscesses and gallstones.

When Borell first applied for disability, his claim was denied, he said, on the basis that his surgery cured his cancer. Following his request for reconsideration and a subsequent hearing before an administrative law justice, he was awarded disability benefits retroactive to the time of his disability. By that time, 18 months had passed.

While waiting for disability benefits, he collected welfare—later he had to pay back the $2,000 he received during that time—and nearly lost his home in the Kensington section of Philadelphia because of difficulty meeting his $100-a-month mortgage payments.

In October 1978, 10 months after he first received disability payments, the Social Security Administration notified him that he no longer was disabled by "cancer of the colon" and cut off his benefits.

Ms. Marquez, who represented him during his appeal in January 1979, appeared at the hearing armed with Borell's medical records, including a 42-page report from Parkview Hospital. Borell's benefits were restored in May 1979.

"If this were the exception instead of the rule, I'd be less angry than I am all the time," said Ms. Marquez, who spends most of her working hours on such cases. "With some people, despite overwhelming evidence to the contrary, somebody decides they're not disabled, and they think, 'Well, I must not be disabled; the government wouldn't do that to me.' It drives me crazy."

The Social Security Administration defines disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected or last for a continuous period of not less than 12 months."

Nationally, Social Security pays out about $22 billion a year in disability benefits to almost 5.2 million people via two programs: Disability Insurance (DI), first enacted in the 1950s as a program for disabled workers over age 50 (and later liberalized to include younger persons and dependents), and the newer Supplemental Security Income (SSI).

Financing for DI comes from payroll taxes; SSI is funded by general revenues and pays benefits to blind and disabled people of low income.

One of the major problems within the system, its critics and supporters agree, is the double standard under which benefits are determined.

The state agency, which initially decides whether a person qualifies, applies purely objective information that is contained in the applicant's medical records.

Those who hear the appeals of the state agency's decisions, the administrative law judges, who are employed by Social Security, and federal judges, are permitted to apply subjective judgments, such as the consideration of pain, and to seek additional medical evidence in support of a claimant's case. The clash between the two parts of the system is apparent in the statistics regarding application, denials and appeals.

About 70 percent of all applications for disability benefits are denied by the state agencies, according to a report issued last month by the Special Senate Committee on Aging. About 60 percent of those who appeal their cases to administrative law judges are having their claims upheld.

In cases reviewed by state agencies, about 45 percent were being terminated, according to the same study. Administrative law judges are reversing more than half those termination decisions.

The Social Security Administration is currently reviewing the decisions of about 70 to 80 administrative law judges, out of a total of 800 around the country, and critics say that such reviews, directed at judges with high reversal rates, are an attempt at pressuring the judges to deny more claims.

In testimony last month before the House Ways and Means Committee, which is considering changes in Social Security law, Social Security Commissioner John A. Svahn acknowledged that "the requirement that we review only favorable determinations leads to a built-in bias in the system that results in states using the rule of 'when in doubt, throw it out.' "

At least two administrative law judges in the Philadelphia Hearing Office see the reviews as "an honest attempt to get consistency in standards."

"Maybe I'm naive", said one of them, who requested his name not be used, "but I think [Social Security] really wants to know why the wide disparity."

Another Social Security employee, however, who also requested that his name be withheld, says "Let me tell you, these guys [administrative law judges], are a little gun-shy [about talking to the press]. They're public servants just like I am, and they're afraid someone's going to stomp on them, just like I am."

In an ironical twist, the GAO, whose study triggered the review process, has been asked to investigate allegations that the reviews are being poorly administered.

Heinz, who is chairman of the Senate Special Committee on Aging, which has been closely following the issue, requested the GAO investigators to "look at what's going on in Pennsylvania," said Heinz aide McArdle.

The investigators, who also will visit New York, California and Ohio, are scheduled to talk with hearing judges in Harrisburg tomorrow, McArdle said, to see how the situation in Pennsylvania compares with the rest of the country. The plan calls for an extension of the study in May, he added, to give investigators a broader statistical study.

The GAO investigation is not the only effort under way to alleviate the problem.

The House Ways and Means Subcommittee on Social Security has been hearing testimony over the last several weeks on a bill, HR 5700, that seeks to modify Social Security law. Introduced by committee chairman J. J. Pickle (D., Texas), the bill seeks to relieve some of the problems brought on by the reviews.

Among the provisions of the bill, which was reported out of committee last week, are expanded rehabilitation services for those terminated, a continuation of benefits during the reconsideration period and an extension of benefits for an additional four months for those who have been on the disabled roster at least three years.

Stein of CLS considers the bill "very inadequate." He objects especially to a provision that would bar new medical evidence on a claimant once a case goes beyond the reconsideration level. Currently, new evidence may be introduced before administrative law judges, the next step on the appeal ladder.

Stein said the bill "assumes a need to coerce the complainant to bring evidence up earlier. Reality negates [such action] totally. [The claimants] have no money, no idea of what is necessary to prove, and it takes a certain amount of time, energy and education which many complainants don't have."

On Tuesday, Stein filed a class-action suit in U.S. District Court on behalf of all those in Pennsylvania who "have been or will soon be the victims of a disability review process that fails to ascertain whether there has been medical improvement" in the disabled person's condition.

The issue of "medical improvement" has become the source of considerable discussion. On several occasions federal judges have ruled that before benefits can be discontinued the Social Security Administration must prove that a claimant's condition has improved. That once was the agency's policy as well, but the requirement was dropped several years ago, with the result that state agencies can drop recipients more easily.

"For the most part, we think the state agencies are making good decisions," said John Trollinger, a spokesman for the Social Security Administration at the Baltimore headquarters. "The system is not perfect. If mistakes have been made, they will be corrected."

Stein disagreed. "We're talking about probably the most vulnerable class of people in the United states, who cannot tolerate the physical and emotional distress that comes from loss of income. There's no way of making up for that."

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[From the Philadelphia Inquirer, Wednesday, Apr. 14, 1982]

## Disability Cases Involve People, Not Just Paper

President Reagan told an interviewer recently that after he saw a television program "I went storming into the office" and demanded to know "what are we doing?" The program had asserted that a Fredericksburg, Va., man named Stuart Kindrick, who had for several months lost his Social Security disability benefits, was a victim of "Reagan budget cuts."

We hadn't taken him off [the disability rolls]," Mr. Reagan told the interviewer. "He had been taken off in 1980 because it was found then that he was holding a job for three years while he was drawing disability payments."

Mr. Reagan had his facts wrong. Technically the man was not a victim of "Reagan budget cuts," since the accelerated review of Social Security disability cases had begun in 1980. But the review has been escalated under the Reagan administration. Mr. Kindrick, who had suffered brain damage in an industrial accident, had been taken off the rolls in 1981. And he had been put back on several months later, and with a check for $2,314.24, when officials reversed themselves.

What *are* they doing?

They, meaning the Social Security Administration staff, are cutting off disability payments wholesale, with the expectation of saving hundreds of millions of dollars. They are going far beyond the Congress' intent, with which no one could reasonably quarrel—that is, to review caseloads and weed out the truly unqualified. They are, rather, as Sen. Donald Riegle Jr. (D., Mich.) put it, engaged in a "massive assault . . . against our nation's disabled citizens."

Some of the results are tragic. Sen. Riegle cites the case of the 46-year-old Lasing man who, after learning that his disability benefits for a serious back injury had been cut off, shot himself to death in front of his local Social Security office.

In Sunday's Inquirer, reporter Mary Jane Fine cited the case of the Vietnam veteran who, with one leg amputated at the knee, two figures gone, his spleen and part of his stomach removed, his jaw wired shut and part of his buttocks shot off, was informed about six weeks ago that his $400-a-month disability benefits were being cut off. Medical records, he was advised, indicated that he was no longer disabled and could therefore "engage in substantial gainful activity."

What *should* they be doing?

Obviously, they should be carrying out the intent of the Congress, which is to serve the interests of the taxpayers. It was not to make arbitrary decisions on the assumption that anyone with a disability claim is probably a cheater. The General Accounting Office study that triggered the Congress' action concluded that the vast bulk of claimants are not. Significantly, people who appeal the decisions, made initially by state agencies, are being upheld by administrative law judges about 60 percent of the time.

The bureaucrats reviewing the roster ought also to realize that many of the disabled have no idea of what their rights are and get lost in the jungles of red tape, and that some of them have psychiatric problems that make them at the same time eligible for disability but unable to challenge a decision to deny.

As a matter of fairness, not to mention compassion, disability payments should be continued, not cut off, until claimants have full opportunity to have a hearing before an administrative law judge.

Stuart Kindrick, the man whom President Reagan wrongfully accused of being a cheater, was in fact a victim of overzealous bureaucrats. No one can expect that bureaucrats, being human, will never make mistakes. They will make fewer mistakes, however, if they will recognize that the cases they are deciding also involve human beings.

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[From the Washington Post, May 3, 1982]

## Margin for Error in Screening Social Security Disability Rolls

(By Jane Bryant Quinn)

New York—An estimated 1 million people are expected to be removed from the Social Security disability rolls over the next two or three years because the law says they don't belong there.

Most of them are not cheaters in the usual sense. They are people who consider themselves disabled, but who no longer meet Social Security's tough eligibility standards. A good number of them will have trouble finding work.

A certain number of people will be removed by mistake and should act fast to find a lawyer. "In this fiscal year we will have to make more than 2 million decisions and some of them will be wrong," says Rhoda Greenberg, director of Social Security's Office of Disability Programs.

Under current law, a disabled person has only 15 days (including mailing time) to tell Social Security that he or she wants to contest the cutoff, and a maximum of 25 days to submit new evidence that he really is unable to work. Many people find that it's hard to get a doctor's report within 25 days, let alone get a case together. If he is turned down again, he has 60 days to appeal to a judge.

In the past, Social Security rarely reviewed disability cases. Once on the rolls, a person normally could expect to stay there. But under a law supported by President Carter and passed in 1980, non-permanent disabilities will be reviewed at least once every three years.

Reviews were not supposed to begin until January, 1982, to give the state agencies time to staff up for the job. But President Reagan accelerated the process. Since March, 1981, 436,000 cases have been examined, and 174,000 people cut off.

The computer scan is starting with younger workers, workers getting higher benefits and workers who entered the program in the mid-1970s when changes in law brought large numbers of people onto the rolls. "Our studies show that people with these characteristics are more likely to be candidates for cessation," Greenberg says. But eventually everyone will be reviewed, including those with permanent disabilities.

Termination comes with startling suddenness. Checks stop roughly two months after a person gets his notice. If he appeals and is eventually returned to the disability rolls (as will happen in many cases), payments will be made for the months he missed. But it could be hard living until then.

A bill now before the House Ways and Means Committee would let payments continue for up to six months while a case is being appealed. (If you lose the appeal, however, you might have to give some of the money back.)

The bill also gives people at least six full months of transition benefits, if they had been on the disability rolls for three years or more; it stops the agency from billing people for back payments if a medical review concludes that their disability ended some time ago; and it gives them up to six months to appeal, instead of only 16 days.

These changes will ease the hardship of sudden and tardy reviews, while still letting them proceed. The practice of billing ineligible people for back payments would resume in 1985.

Regrettably, Social Security beneficiaries get second-class treatment in the government's disability scheme. To be eligible, you must be totally disabled with an ailment expected to last at least a year. You can be eliminated from the program if you appear capable of doing any reasonable work.

A low-income veteran, on the other hand can get payments for only a partial disability, even if his problem has nothing to do with military service. Federal employes, as well as many state and city workers, enjoy taxpayer-funded disability programs that are far more lenient than Social Security's. Many of the cases of abuse that you read about arise from state or veterans programs, yet only Social Security is up for sweeping review.

Anyone who gets a termination notice from Social Security, yet believes himself to be truly disabled, should probably not risk appealing by himself. Experience shows that you're more likely to get your benefits back if you have a lawyer prepare your case.

To find a lawyer experienced in Social Security work, call a legal-aid office, the Welfare Department or the National Organization of Social Security Claimants Representatives (toll-free 800-431-2804; in New York state, toll-call 914-735-8812.) The fee is usually up to 25 percent of any back benefits you collect, and nothing (except perhaps expenses) if you lose.

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[From the Washington Post, Sunday, May 9, 1982]

## On and Off the Rolls

The administration's response to the CBS News documentary "People Like Us" reveals the Alice in Wonderland approach the administration is taking to the problems of the disabled.

Health and Human Services Assistant Secretary Robert Rubin defended the administration's procedure for terminating people from the Social Security disability rules. He indicated the procedure for the most part rooted out only those who are ineligible. Unfortunately, they are also weeding out people who are not well enough to fight their termination from the rolls, much less engage in substantial, gainful activity.

The Disability Determination Services is responsibile for review of those on the disability rolls. As an attorney who deals with this matter frequently, I am appalled by the number of cases in which the Social Security Administration ignors the findings of its own doctors, even when those doctors find severe mental and physical impairments.

These people are often solely dependent on Social Security disability benfits for their income. They are given only about 10 days before the Disability Determination Services ends their benefits. They are then required to spend many months without any benefits whatever before they are able to get to a hearing before an administrative law judge. They must then wait for the judge to issue his ruling and for the Social Security Administration to start the checks again.

The incredible incompentence of the Social Security Administration has had the effect of putting thousands of severely disabled people through a living hell. It has also managed to clog up and already overworked group of administrative law judges.

I am all for getting people who are able to work off the rolls. However, before anyone's benefits are cut off, he should be provided with a hearing before an administrative law judge and be provided with the opportunity to obtain the medical reports that would document his impairments. If members of the administration continue to ignore the tragedies that are going on before their very eyes, then they are surely deserving of the retribution that the voters will provide them in November.

Gregory R. Herrell.

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[Columbus, Ohio Citizens-Journal, May 29, 1982]

## Disabled Man Preferred Death to Loss of Benefits

(By Jim Dillon)

Last Monday, the Social Security Administration informed Rose Kelly of Dublin by letter that her husband's $612-a-month disability benfit was being cut off.

But the letter, dated May 11, was irrelevant. Her husband, William J. Kelly, Jr., 59, a retired lab technician for the Timken Co., had killed himself that day because, according to his wife, he knew the benefits would be terminated.

Kelly's case is one of many the Ohio Bureau of Disability Determination has reviewed for the Social Security Administration.

"I know there are people who shouldn't be on the (payment) list," Mrs. Kelly said in a recent interview in her home at 7979 Dublin Road.

"But I don't think they (state and federal officials) realize the devastation this has caused these people that have been retired for any number of years. I think they were very rash and harsh, and that a very unsound judgement was made on their part."

Kelly was informed March 9 that the Bureau of Disability Determination was reviewing his claim to determine whether he was still eligible for disability payments.

Kelly had been receiving disability payments since October 1976. He had suffered from rheumatic heart disease, a stroke, ulcers, dizziness, arthritis, poor memory and shortness of breath.

On April 23, the state bureau informed him that "the information and evidence" from two doctors and a hospital "shows that you have been able to work since April 1982."

"Medical evidence shows that . . . you do not have a heart-related chest pain or congestive heart failure. Your weight is normal and your dizziness was considered to be due to the medication you were taking, which has been adjusted There are no joint abnormalities or significant memory impairment," the letter said.

The letter said Kelly could perform medium work that required standing and walking for up to eight hours a day and occasional lifting of up to 50 pounds. His disability benefits were scheduled to be ended in June unless he could provide more medical proof that he was truly disabled.

Kelly also received a $324-a-month pension from the Timken Co.

According to Mrs. Kelly, her husband became so distraught over the possible loss of his disability payments that he entered Riverside Hospital on May 1.

He was released May 11, ironically the same day the Social Security Administration mailed him the letter saying his benefits would be terminated.

While his wife was shopping that afternoon, Kelly wrote a suicide note, walked into his garage, placed a gun against his head and pulled the trigger.

"He just couldn't fight any longer." Mrs. Kelly said. "His note said he couldn't take the pain anymore."

Bruce Hickin, area manager of the Bureau of Disability Determination, said the bureau simply is following 1980 amendments to the Social Security law that require the review of disability cases.

The Social Security Administration chooses the cases to be reviewed, Hickin said. The state bureau contracts with the federal government to perform the spot checks of disability cases in Ohio, Hickin added.

During the past year, the Social Security Administration has ordered more cases reviewed, Hickin said. All final determinations are made solely on medical evidence.

The increased reviews and the drastic measures some people, like Kelly, are taking has alarmed Sen. Howard Metzenbaum, D-Ohio.

"We've started seeing an awful lot of people calling here saying that they had been on disability for eight years, 10 years, 15 years and saying, 'I've suddenly been terminated and they say I can go back to work. And I can't. I'm disabled'," said Marian Harris of Metzenbaum's staff.

Metzenbaum believes many of the benefit payments are being terminated unfairly, she said. "People are just destitute. It's awful."

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[From the Philadelphia Inquirer, June 4, 1982]

## U.S. Drops Loss-of-Benefits Letters

(By Tom Masland)

Chicago—The Social Security Administration has stopped using a form letter that invites people fighting their loss of federal disability benefits to drop such appeals.

A government attorney announced the decision here Wednesday during a court hearing on a suit filed by six administrative law judges employed by the Social Security Administration who had disobeyed orders to distribute the notices.

Louis B. Hays, associate Social Security commissioner in the agency's office of hearings and appeals in Chicago, said yesterday that the decision to stop using the letters had been made before the judges filed suit Tuesday.

Judges who refused to mail the letters would not be disciplined, he said. A further hearing was scheduled in the judges' case, however.

Some judges, whose job is to hear appeals in Social Security cases, had argued that the notices undermined their impartiality, making them appear biased against those appealing their loss of disability benefits.

The issue of the notices is part of a growing national debate over a wide-spread Social Security Administration review of disability payments mandated by Congress in 1980 and accelerated by the Reagan administration.

Critics, including some members of Congress, charge that the disabled are being disqualified wholesale to save money in the $20 billion program.

In the initial reviews, about 40 percent of recipients are being found unqualified for the program. But of those who request a new hearing before a judge, more than 60 percent win their benefits back.

Last month, all Social Security Administration Administrative law judges were ordered to mail the contested form letter to people whose appeals were pending before them.

The letter explains a recent policy change regarding the effective date of disability cutoffs. The letter told cut-off recipients that they were eligible for benefits up to the time they received their cutoff notices; previously, they could be billed retroactively for payments made after the initial review judged they were able to work.

"Based on this change in our decision, you may wish to withdraw your request for a hearing on the termination of your disability benefits," the letter continues. Included in the letter is a short form with which the recipients could drop their appeals, and a prepaid envelope.

Some judges have protested that the wording of the letter gives the impression that a judge has already ruled on the appeal. Other critics have said that disability recipients, many of whom are poorly educated or mentally handicapped, can be misled into thinking they have won back their full benefits.

Hays said yesterday that the section of the letter inviting recipients to drop their appeals would be deleted, and that language explaining the change in eligibility dates would be clarified.

"The [Social Security] commissioner decided he did not like the notion of asking if people wanted to withdraw their request for a hearing," he said.

During Wednesday's hearing, U.S. District Judge John F. Grady denied the judges' request for a temporary restraining order barring the Social Security Administration from requiring them to send out the notices. He scheduled a hearing on the suit for June 16.

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[From the Philadelphia Daily News, June 10, 1982]

## SHE LOST HER BENEFITS, HER WILL TO LIVE

(By Julia Lawlor)

They were an odd couple, walking into the offices of Community Legal Services on the Friday before Memorial Day: a middle-aged man in a winter coat, and a plump, dowdy woman in mismatched clothes, clutching a letter from a judge.

"Neither of them understood what was going on," said Beverly Lucas, a CLS attorney who talked to Kathleen Mitchell McGovern and her boyfriend, Joseph Finnegan, that day. "But I know she was upset when she first came in."

The letter, from Administrative Law Judge Morris Chernock, advised McGovern, a 40-year-old woman with a nine-year history of hospitalization for paranoid schizophrenia, that the Social Security Administration would stop her disability benefits of $297 a month at the end of May.

Six day later, at 6:01 p.m. on June 2, police received an anonymous call that McGovern was dead.

She was found in bed at her apartment across from the Albert Einstein Medical Center's Daroff Division, 5th Street near Reed. Police said Finnegin was there when they found the body.

Jonathan Stein, chief of special projects for CLS, believes McGovern committed suicide by taking a mixture of alcohol and pills because she was despondent over losing her benefits. The decision to end her benefits, he contends, was "grossly erroneous, [and] not based on current medical evidence."

"The decision came the day after she had been hospitalized for two weeks at Einstein Southern," he said. "They simply had to pick up the phone [to call her doctor]. She was severely depressed. This is a bureaucracy gone crazy, making the most unjust, arbitrary decisions."

Although the cause of death has not yet been determined, a source in the medical examiner's office said suicide is suspected because McGovern had "no medical history that would probably cause her death," and no signs of any external injuries. Further tissue tests are being performed to determine if there was an overdose.

U.S. Sen. John Heinz, R-Pa., has asked officials of the Government Accounting Office for an investigation into McGovern's death, said Frank McArdle, a spokesman for Heinz. McArdle said the GAO would try to determine whether the case was handled properly, whether Social Security investigators knew McGovern was suicidal, and, if the death was a suicide, to what extent it could be linked to the loss of benefits.

McGovern, Stein said, was "one of the victims of the assembly-line review system" set in motion when Congress mandated a review of more than six million people on Supplemental Security Income and Social Security Disability Insurance in 1980. Although the review was scheduled to begin in 1982, the Reagan administration started it in 1981, thereby cutting off 175,000 people between March 1981 and March 1982 and saving a reported $200 million.

Kathleen McGovern was diagnosed as a paranoid schizophenic in 1973 by Dr. Theodore Wasserman, chairman of the Department of Psychiatry at Einstein's Daroff Division. Because her symptoms were so severe, she was transferred to Philadelphia State Hospital at Byberry for six months.

For the next nine years, said Wasserman, she was hopitalized periodically, suffering from alcoholism, depression and other medical problems.

The first interview Beverly Lucas had with McGovern was long and rambling. McGovern was upset over the loss of her benefits.

"She didn't focus on what we were there for," Lucas said. "I didn't get a lot of information out of her. She talked about her boyfriend a lot. she was quite happy about him. But she got really excited about a soap opera character, I can't remember which one. She was really getting into it like that person was real."

Dorothy Murray, 55, McGovern's first cousin, remembers her as a "pretty little girl" with curly blonde hair and blue eyes. The two grew up around the corner from each other in West Philadelphia.

"She had a loving and caring mother and father," Murray remembered, "an older brother and two younger brothers. The younger boy was retarded. When she was in the sixth grade, a teacher noticed something was wrong. It was emotional. One time, her mother took her to a doctor and he said she'd be capable of getting married, keeping a house, but she wouldn't be outstanding in the world. She did mostly waitress work. But it was hard for her to keep a job."

McGovern's last hospitalization, according to Wasserman, was in early April at Einstein, when she became suicidal and was hospitalized for depression. "She was depressed over having received the first letter," he said, "and she went to the emergency room and said she wanted help. We talked about an appeal. Although she was suicidal and depressed, she didn't take this lying down. She got a clinic lawyer, and she came in to me with a request [to write a letter outlining her mental problems]. I thought she was pretty aggressive about it."

In his letter, dated April 29, which was to have been a part of the appeal before Judge Chernock, Wasserman wrote:

"Her ability to relate to people is very limited. She is super-sensitive to what people say and frequently becomes paranoid about their comments. It is my impression that . . . because of her appearance and regular need for psychiatric hospitalization, she is unemployable."

Although Wasserman had been McGovern's physician for almost nine years, his medical opinions were not included in two decisions by Pennsylvania's Bureau of Disability Determination, the state agency that reviewed McGovern's case.

"If they did a conscientious, careful job," Stein said, "they would have called Wasserman. They don't care about the medical history of the beneficiary [and] that's unprofessional and unethical. No doctor would ignore past medical history."

"Although she depends on others and has structured her living to such," the decision dated Jan. 13, 1982, reads, "there [are] no marked restrictive qualities to her day-to-day living or her ability to interact with others . . . Her relevant work history is that of a waitress, a semi-skilled light occupation which would require superficial contacts and routine repetitive movements."

The state agency's decisions were based on evidence from three sources, according to the report: Dr. Jon Bjornson, also a psychiatrist at Einstein's Daroff Division; two admissions to Einstein in 1979 and 1981; and a 1981 report from Market East Medical Associates.

Bjornson, when contacted yesterday, said he had not known of McGovern's death and refused to discuss the case.

Rose Lepore, regional commissioner for the Social Security Administration in Philadelphia, said there was a "statement" from Wasserman in McGovern's file from 1975, the year McGovern's benefits began. She said McGovern had seen other doctors, and that attending physicians' statements are not necessarily given more weight than other physicians' statements. "We took the word of the doctors currently treating her," she said.

McGovern was suicidal, Lepore said one of the statements indicated, but added that the condition was in "remission."

Even if a person is suicidal, she said, it does not necessarily follow that benefits will be continued.

"I don't know why the individual took her own life," Lepore said. "Its tragic, I'm very disturbed over that. It pains me that anyone would say it was the letter she got. I'm saying to myself, was that the reason?"

In September 1981, Jackie Parker, an assistant to U.S. Sen. Carl Levin, D-Mich., conducted a 26-state survey and found that Social Security disability beneficiaries were being cut from the rolls because of errors made by overworked and untrained staff workers. She also began to see a trend—suicides that were clearly the result of people becoming despondent over losing benefits. So far, she said, there have been well-documented cases nationwide.

In three state offices of the Bureau of Disability Determination, staff members have been given training in the past two weeks on handling "emergency situations," a spokesman said.

Ironically, the letter McGovern received a week before her death from an administrative law judge was a form letter that was discontinued last week by Social Security after a suit was filed in Chicago by six judges who objected to sending the notices.

The letter, which was mailed last month to people who had appeals pending, explained a change in dates of disability cutoffs, telling recipients they would not be billed retroactively for payments they received after the initial review was made. It went on to invite claimants to withdraw their hearing requests, and included a postpaid envelope.

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[From the Washington Post, June 14, 1982]

## SOCIAL SECURITY'S "INJUSTICES"

Social Security Commissioner John A. Srahn's recent public explanation for the scandal involving termination of Social Security and SSI benefits to clearly disabled people who have already met the strictest tests for these benefits, fails to address the magnitude of the errors being made and never explains the causes for these arbitrary terminations.

Statistics illustrate that once terminated, beneficiaries obtain their first and only face-to-face and independent hearing in the system, currently 60 percent get their terminations reversed and over half of the others losing at the hearing stage succeed when they take their cases to federal court. Thus, one gets a better picture of how unfair and illegal the great majority of the over 175,000 terminations have been in the March 1981 to March 1982 period.

There are many reasons for these shocking terminations, some constituting longstanding inequities in the disability determinations process:

It is simply impossible for state disability determination review agencies to review fairly 540,000 cases this year, 860,000 next year, more thereafter, and our disabled clients are asking that the 1980 amendments calling for these mass reviews should be reexamined and rescinded;

State review agencies never see the beneficiaries face to face to evaluate the disability, especially subjective complaints;

Social Security, without public notice or changes by Congress in the Social Security Act, has improperly narrowed standards by which disabilities are evaluated, and is now seeking in the name of "uniformity," through H.R. 6181, to impose these secret, internally published standards upon their administrative law judges;

State review agencies ignore or fail to obtain medical evidence from treating physicians and fail to afford it proper weight, while relying solely on cursory, one-shot consultative examinations by doctors who don't know the beneficiaries and don't have any medical history;

Contrary to law, state agencies ignore vocational factors; they ignore non-exertional factors such as mental impairments and, most shocking of all, they ignore the reality of pain in evaluating disabilities;

Social Security no longer deems it necessary to show that there has been substantial medical improvement in the disabled beneficiary's condition since the person was previously found by them to be disabled, thus treating the beneficiary as if he or she was applying for the first time.

The inequities arising from the mass review of 30,000 cases a month currently being shipped out for state agency review are made that much more harsh for the tens of thousands cut off, only later to be reinstated on appeal, because current law does not permit disability insurance benefits to continue pending the administrative hearing decision when there is an appeal.

Thus, innocent, severely disabled people, who as past wage earners have been the backbone of our nation, must wait over a year or more for reinstatement while they suffer loss of medical care, their homes, necessities of life and even life itself, as the suicides of some beneficiaries have sadly demonstrated.

I hope the hearings recently held by the House Select Committee on Aging and the oversight subcommittee of the Senate Governmental Affairs Committee will lead to the most prompt remedical action to right these injustices.

JONATHAN M. STEIN,
*Chief of Special Projects, Community Legal Services.*

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[From the Detroit News, July 25, 1982]

## IN THE MATTER OF FRANK WILLIAMS' BACK * * *

(By John McAleenan)

Frank Harrison Williams has a bad back.

Not *just* plain old bad. Too many foggy, pain-killing, mind-altering pills every single day bad. Holding for dear life onto the living room chair bad. Screaming at the bedroom ceiling at 3 o'clock in the morning bad. Standing up bad. Sitting down bad. Picking up a little bag of groceries that seem loaded with concrete blocks bad.

That bad. He says so. His wife says so. His doctor says so. His attorney says so. His three kids say so. His neighbors and friends say so. In fact, just about anyone who would chance to visit Frank at his home, watching him shuffle around, bent over like a question mark, would say so.

That should, in the normal course of events, be more than enough people agreeing on Frank's bad back to settle the matter once and for all.

Frank, at 35, would continue to receive his $1,000-a-month disability payments—and while that wouldn't do anything to make Frank's bad back any better, it would certainly ease quite a bit of both psychological and economic pain in the Williamses' west-side Detroit household.

But—before you decide *real* bad—we have another opinion here.

It is held by an administrative law judge in the Department of Human and Health Services, Social Security Administration, Office of Hearings and Appeals.

On June 11 of this year, Judge Gary E. Lowe, after previously listening to two hours of testimony and reading several documents, dictated a six-page appeals decision that, among many other things, decreed the claimant (Frank Harrison Williams, SS No. 383-46-3736) had been able to stand in the courtroom on several occasions; did appear rather hostile to the proceedings as a whole; that the claim he spent 22 hours a day in bed was totally "ludicrous and preposterous"; and that Frank's doctor's reports (fully supporting the disability claim) were "inconsistent."

Further, Judge Lowe wrote: "The claimant appeared to be strong and healthy, further supporting the conclusion the claimant is not experiencing disabling pain." And later into the decision: ". . . the claimant cannot be (as) restricted as he alleges while maintaining normal weight, good muscle tone and adequate strength."

And finally into the decision: ". . . the claimant's alleged restrictions, limitations and daily habits are totally incredible."

All of which is too say Judge Lowe certainly agreed with the Social Security Administration's decision to cut off Williams' disability benefits last October. Not only that, but there was no reason in the world he could think of that Williams could not apply for a "sedentary" job someplace—where he could sit down for a while, stand up when that got too painful, and then sit down again, and then stand up again, and so forth.

At the hearing, an Elaine Trippi, testifying as a vocational expert, told the judge there were 30,000 such jobs, currently available in Michigan that Williams could apply for, at least 10,000 of those being in the Detroit area. She failed to mention any *specific* ones, however.

It ended, at least for the time being, on a dry, bureaucratic note: that the claimant, considering his maximum sustained work capability, age, education and work experience, be found "not disabled."

Frank Harrison Williams had something *very* hostile to say when he learned of that decision, but it will not be printed here.

And Williams is certainly not alone in this predicament. In Michigan, and all across the country, thousands of disability files are being hauled out of file cabinets and reviewed with increasing vigor. If you are on the short end of this situation, you would call it an "unfair crackdown." If you work for the Social Security folks, it's simply a "tightening up" procedure—and given the tone of the Reagan Administration on these things, it will continue for some time to come.

The letter arrived at The Detroit News a couple of weeks ago, It began: "I'm writing to you out of fear, hate, sorrow, tears—and could become a mourner. . ."

The writer is Beverly Williams. She writes about a person she has loved for 18 years, her husband, Frank. She is worried that one day, not too far down the line, he will become tired of the pain, the frustration, and perhap try to hurt himself.

If this happens, Beverly will have no problem about whom to blame. She will point her finger directly at a government agency titled: Department of Health and Human Services, Social Security Administration, Office of Hearings and Appeals.

As far as Beverly is concerned, it will be "the system" that has run over her husband—and if down that line it doesn't *actually* lead him down a dead-end road, it will have very effectively stolen the laughter, the joy, the happiness from the man she once knew.

In its place it will give her, *has* given her, a man who suffers. A man in anger. A bitter man who can no longer pick up his children and finds his last refuge in a vial of pills and a lonely bed.

The letter continues: "Tell me, how can they get away with this? My husband has had two back surgeries and may have another one. He's in constant pain all day, every day. Some days are worse than others. He's on medication that keeps him coming and going. Some days he is in so much pain my children and I can hardly stand it because it makes him so evil . . . you know what I mean? It's hard living with a person who is in pain all the time . . ."

Southfield attorney Kenneth Stern, William's counsel, is going to keep on trucking with this matter. He has filed an appeal for a review with the Washington, D.C., Social Security board. Should that fail—and he expects it will—the next step is the federal District Court.

Stern sees it this way: "In Frank's case, I think it was simply a travesty. Just a travesty. I can certainly understand why he's angry. And I can understand why the judge thought he was 'hostile' at the hearings. I would have been hostile, too. It's very, very difficult to harmonize the wide discrepancies you run across in disability reviews.

"For instance, I've represented dozens of persons much less disabled than Frank, and have won those reviews. I don't have the slightest idea why they picked Frank out for a re-examination. Maybe because he was relatively young and would be eligible for long-term benefits.

"Williams was examined—but the important thing to remember here is that he saw a doctor that was hired by the Social Security Administration. Favorable results for that department are *obviously* expected. Frankly, I call them 'hired guns.' The doctor they sent him to for an examination saw him once, had never treated him, and yet the results of that brief visit were given priority over a report filed by his own physician, a surgeon who had been treating him for almost eight years. That simply doesn't make any sense to me."

The letter continues: "He has been going to a doctor every week for a long time for heat treatments. That's the only thing that keeps his muscles from locking on him. Some days he can't even dress himself. Now the Social Security people tell him he can go back to an old job he had 15 years ago at Ford Motor Co. Guess what that job was? Picking up beams of steel and inspecting them. This man cannot even pick up his own children. How in the hell can he pick up some steel? . . ."

Madison Heights surgeon Dr. Lawrence Weisman first saw Frank Williams June 17, 1974, for injuries he had suffered a week earlier in an auto accident. The complaint was spinal pain. In August of that year, after more than a month of being treated with muscle relaxants, analgesics, heat and ultra-sound therapy and traction, a lumbar laminectomy operation was performed at Highland Park General Hospital by a consulting neurosurgeon.

In lay terms, this is an excision of a ruptured spinal disc. The muscle relaxants, the analgesics and the heat treatment continued, but Frank got no better. In fact, he got worse. In May of 1975, he underwent a second laminectomy operation at North Detroit General Hospital.

Frank fought with his pain and continued to see his doctor on a random basis over the years. He quit his $375-a-week landscaping job four years ago because . . . well, because he simply could not cut down trees any longer.

In April of this year, Dr. Weisman wrote that Williams showed "a 35 to 40 percent limitation of motion in the lumbar spine." A "decreased range of left hip motion" was also noted. Frank was hospitalized for the third time last week. There will be a long series of tests and a hard decision yet to be made as to whether there should be a third laminectomy operation.

Dr. Weisman wrote a letter last April that was introduced as evidence in Williams' disability hearing. It chronicled the events, treatments and operations over the eight years and ended this way:

"In light of his (Williams') persistent complaints and objective physical findings, he will require additional treatment for a protracted length of time. Accordingly, his prognosis must remain guarded and he is totally and permanently disabled from performing any manual work and/or any type of work which involves sitting for any prolonged period of time."

As a postscript, Dr. Weisman will add:

"Frank Williams told me, as he tells other people, that he thinks he's getting screwed. I agree, totally. And it's not just him, it's people like him all over the country these days. He's standing up. He might even win eventually. But most people don't fight back—and the government is getting rid of most of these cases by simple default.

"As to Frank, well, he's had two shots at an operation that *should* have made him better. As you go down the line with this type of thing, the chance of success becomes less each time. A third one is a *very* marginal option.

"He has a bad back. He'll have a bad back for the rest of his life. Period. It won't get any better and very probably will get much worse. There's no question about that in my mind. I don't see him in a wheelchair, but I also don't see him with a life that's going to be an awful lot of fun. That's too bad."

The letter continues: "I told them at the hearing about the hours he has to spend in bed. I told them about the medication. I told them how I had to help get him dressed. I told them that on some days his memory is not the best. I told them *everything* I could, all the time trying to hold back the tears. Because it's all true. We didn't have to lie. The judge said, Let's presume' Frank can do this and Frank and do that . . . well, the judge was presuming things that Frank *cannot* do. Then the judge says because my husband 'looks' healthy enough, he can go back to work. They didn't mention my husband's hand shakes like a 90-year-old man. They didn't consider the pain he is in.

"They did not see my husband before and how the pain has changed him in the past few years . . . now my husband is talking about killing himself. He says he can't beat the system that doesn't want him to exist. He has no income. He can't get state aid because I work. We can't even afford to get all his medicine. It's awfully hard for a person who is used to working and taking care of his family to be in that position. Illness is no game and pain is no fun. I truly believe my husband has a right to his disability . . ."

Judge Gary E. Lowe is from Kansas City and has been working out of the Social Security Hearings and Appeals office in Southfield for the past year or so. Because there are avenues of appeal still open in the Williams case, he feels it "inappropriate" to comment on that matter. Which is not to say there will be no comment at all. Like this:

"I can tell you we try to give each person a full and fair hearing. It's not an adversary proceeding. Not at all. I haven't the slightest idea why any person's benefits are terminated. That's not my job. My job is to hear the appeal once they have been discontinued.

"It's difficult sometimes because it's not always black and white, it's not always right and wrong, and some of the cases are very, very close. I, and the other judges, can only do what the government pays us good money to do—and that is to use our best judgment in each case. I don't personally recall Frank Williams or the details of the matter simply because I try to shut that out my mind after it's over. I try not to take this stuff home with me."

Frank Harrison Williams is in Room 408 at North Detroit General Hospital at the moment. He doesn't know what is going to happen to him. Not today or tomorrow or all the tomorrows after that. If he were on speaking terms with God—and by his own admission, he hasn't been lately—he would save a little of that disability money and borrow a little more money and maybe open one of those video game arcades somewhere in his west-side neighborhood.

If it hurt too bad sometimes, he could get his son, Darrell, who is 17, to help him. Daughters Dorene, 14, and Doretta, 10, could help out also. It's not a very realistic dream, but right now Frank will take any dream he can get.

"The pain, always dropping those pills, it takes everything away from you. It robs your head. It robs your manhood. I'm not even half the man I was five or six years ago. And what will I be like five years from now? Tell me that. My body is telling me that it's not getting any better. My body is telling me it's getting worse. You want to strike out at something, somebody, anybody. That's how you feel . . ."

Beverly Williams, at 35 a lovely woman with the softest of brown eyes, finished her letter of June 23 by writing: "Help us if you can. Feel free to call. I'm sorry the letter was not in the best of order."

No more than her husband knows does she know what tomorrow will bring. She knows vividly, however, the changes of all the yesterdays. How her husband used to hold her, but can't any longer. How they used to go horseback riding and pack a picnic lunch for Belle Isle, but can't any longer. How Frank used to bring home his paycheck, uncashed, proud of what he had done, what he had earned, but can't any longer. How he used to play with the kids, but can't any longer. How it always used to be "Papa, papa, come see this," and now it is always "Mama, mama, come see this . . ."

Last Monday, she had taken the day off from work as a $13,000-a-year clerical supervisor with the Michigan Department of Social Services to get Frank to the hospital on time—one more time.

It had been a long day, and sitting in the little visitor's room after saying good night to Frank, she looked tired. She was tired.

It was not a long conversation. Mostly about Frank and Beverly and the kids.

"I've been with that guy for 18 years. It's tough right now, but you just don't walk out and leave someone you love. He took care of me for a long while—and I'll take care of him for a long while. I'll stick by him.

"I can imagine how he feels. He doesn't want to feel like he can do nothing. He desperately wants to be a person in our house. If he wins the disability case, that will mean money we need, but more than that, the check will be 'Frank' in a sense. That will be his contribution. If he doesn't get it, it will be hell. Not only for Frank, but for all of us. Me, the kids, all of us.

"The way I think right now is that I'm not going to let this beat me. I've got three children to raise and a husband to take care of. That's all I'm looking at right now. If you think about what has happened too much, it will just drive you crazy.

"So I'm going to go home and cook dinner for the kids, and then later I'll call Frank and see how he's doing. And I'll do the same tomorrow and tomorrow and hope things will change, will get better. That's all I can do, all I can hope for."

And then she cried. Just looked at the old gray wall that was peeling and cracked and thought perhaps about the things that might be, and the way they will never be again. She cried very quietly.

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[From U.S. News & World Report, June 28, 1982]

## THE $4-BILLION-A-YEAR DISABILITY MESS

(By James M. Hildreth)

A government crackdown against abuse in the Social Security system's 18-billion-dollar disability-insurance program is raising howls of protest—but is getting results, too.

In the last 15 months, the Social Security Administration has booted some 191,000 persons off its rolls on the ground that they were ineligible to receive disability benefits. Hundreds of thousands more are under scrutiny.

All told, officials estimate the government sends approximately 4 billion dollars a year in disability benefits to people who don't qualify.

So much hullabaloo is being raised by the campaign that Congress may pass legislation this year to ease the financial pain for those cut off.

Prompting the Capitol Hill activity is a cascade of complaints to virtually every federal lawmaker. A Pennsylvania man, for example, told Senator John Heinz (R-Pa.) that he was cut off the rolls in April after he had received disability benefits for nine years. "My left leg was amputated at the hip point" in 1973, his letter to Heinz said. "Since I have a permanent impairman, and there has been no improvement, I cannot understand why I received notice of termination."

Playing God.—Even more unsettling to critics of the disability reviews: Since the rolls began to be pared in March, 1981, at least nine persons in seven states have committed suicide, leaving messages that linked their deaths to the loss of their disability benefits, according to the staff of Senator Carl Levin (D-Mich.).

In Lansing, for instance, a 46-year-old man shot himself fatally in front of the local office of the Social Security Administration. "They're playing God," his note said.

Claims Jonathan Stein of Community Legal Services in Philadelphia: Thousands of persons are receiving "callous, almost punitive treatment" from the government. Representative Claude Pepper (D-Fla.), Chairman of the House Select Committee on Aging, characterizes the eligibility reviews as nothing less than "a wholesale purge of the disability rolls."

Social security officials defend the reviews as necessary and proper. They note that the 4 billion dollars a year in estimated erroneous payments is nearly 28 percent of all benefits paid. In all, say officials, $7,480 per minute is being wasted on disability benefits to people who don't deserve them.

Congress General Accounting Office backs up the claims about wide-spread errors. It says it found 2 billion dollars in erroneous payments to as many as 584,000 people in 1979—about 20 percent of all disability-insurance recipients at that time. Many of the beneficiaries "should have never have been placed on the rolls initially," says GAO official Gregory Ahart.

Who are these people? Many of the faulty payments are made to persons who continue to receive monthly checks even though they are working full time. Cash if flowing, too, to persons whose medical problems have improved to the point that they can obtain some type of job. Social Security Commission John Svahn acknowledges that the government's disability rules are "very tight" on this core. He points out that "a person who has lost a leg can easily work, for example, as a parking-lot attendant," thus making that person ineligible for benefits.

Another abuse cited: Sending checks to about 3,000 prison inmates whose crimes include murder. Congress has halted that practice, but some payments continue to slip through. Still other checks are going out to dead people.

All of this turmoil is swirling around a program that first became a part of the Social Security system in 1956. The goal: to place a federal safety net under those persons who are forced by physical or mental disability to quit working before reaching the minimum age for drawing old-age pensions.

*Mushrooming lists.*—The program proved popular, with more and more people being added to the rolls during the 1960s and early 1970s. Claims for benefits soared by 500,000 between 1969 and 1974 alone. One reason: Congress liberalized eligibility requirements. At the same time, very few recipients—just 3 percent in 1973, for example—were checked to determine if they were still disabled or jobless.

The effect of these changes is that about 2.8 million workers now draw disability payments, with the average check totaling $413 per month. Add dependents, and the total of recipients swells to 4.5 million persons, compared with 3.3 million in 1972.

Total benefits paid in the 1982 fiscal year ending September 30 will come to an estimated 17.7 billion dollars, more than three times higher than was paid a decade ago.

Money to pay the benefits comes mostly from a payroll tax—on both employer and employe—of 0.825 percent of earnings up to $32,400 this year. To qualify for benefits, the law says that a person's disability must be expected to result in death or must have lasted or be expected to last, for at least one year—barring the recipient from work of any kind.

In recent years, stricter enforcement of the law has shrunk the number of disability awards. Between 1977 and 1981, new beneficiaries fell by 39 percent. Today, 7 of every 10 applicants are initially being rejected, according to official estimates.

The current controversy centers on people who have been on the rolls for several years and whose monthly checks are being halted. Behind this lies a new law, passed in 1980, that orders Social Security to keep closer tabs on who is receiving benefits. The law mandates that once every three years SSA must review all cases where disability isn't permanent—about 3 million cases. "People have the feeling that once they're on, they will receive disability insurance forevery," says Svahn. "In 1980, Congress said that isn't the case."

Since the reviews began in March, 1981, the files of nearly 405,000 people have been studied. Almost half—191,000—were ordered dropped from the rolls. Later, some 64,000 had their cases overturned on appeal. An additional 433,000 cases are set for review in the 1983 fiscal year.

*Benefits restored.*—Many critics believe that the administration is overzealous in carrying out Congress's 1980 order. Social Security has "clearly gone overboard," complains Representative Richard Ottinger (D-N.Y.). Ottinger and others note that two thirds of the people who choose to appeal their cutoffs have won their cases, with benefits being restored.

The government concedes that some errors are being made. "Sure, we're making mistakes," acknowledges Svahn. "But not nearly as many as people would like you to believe."

One problem that is worrying the administration and Congress alike: The time lag for obtaining an appeals hearing is lengthy, leaving many without any benefits during much of the wait. The backlog of cases before the SSA's 700 administrative-law judges now stands at 143,000—and is growing.

Administration officials contend that some of the backlog is the fault of lawyers who encourage disability claimants to file appeals, many of which take more than a year to settle. "An entire industry has developed from representing disability claims," complains Svahn. One law firm in Los Angeles, for example, has a recorded telephone message that solicits disability clients. The firm's fee: 25 percent of all retroactive payments awarded—potentially thousands of dollars per case.

Whatever the reason for the long queue, it is giving momentum to legislation in both the House and Senate. Already, the House Ways and Means Committee has approved a bill that would extend full benefits for up to seven months after the beneficiary is notified of termination. Under current law, the maximum is just three months. At the same time, the government's appeal procedures are being revamped to make them easier to understand.

But for all the complaints and criticism, the government shows no signs of easing its drive to ferret out abuse in a major social program.

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[From The Wall Street Journal, August 18, 1982]

## CONGRESS CONSIDERS REVISING REVIEW PROCEDURES FOR DISABILITY PAYMENTS TO AID THE BENEFICIARIES

(By Burt Schorr)

Fort Smith, Ark.—Three spinal operations over the past 22 years haven't stopped the pains that radiate downward from Jo Ann Anderson's lower back to her left foot. Nor have the battery-powered electrodes implanted in her spine. Now, because of nerve pressure in and around her spinal column, the 48-year-old former secretary can walk only haltingly with the aid of a cane. She can't sleep more than two or three hours at a time.

In 1969, Dean Harper, then 23, underwent cranial surgery for a pituitary tumor that could be only partially removed. A postoperative evaluation showed the procedure had left him blind in left eye, with weak vision in his right eye and with an IQ of 74. He is considered "borderline retarded." Most of the time since his surgery, Mr. Harper has lived at Westark Retirement Home here. Staff murses say that, like a small child, he must be told when to eat, bathe and dress. His attention span is only 10 to 15 minutes.

Though unacquainted with each other, the Fort Smith residents are companions in misfortune. Because of their ailments, both had long been eligible for monthly Social Security disability insurance checks and Medicare reimbursement of health costs. Both of them, as a result of government reevaluations affecting many thousands of beneficiaries, have had those checks and Medicare benefits cut off. And, like many others both have obtained the opinions of federal administrative law judges that benefits shouldn't have been stopped. Payments have yet to be restored.

One result of the cutoffs is emotional stress. Jewell Bredrick, a former auto mechanic here measures the loss of his $541 monthly disability payment since last January in more frequent asthma attacks, which leave him gasping for breath. "When you're sitting here with no income, you start getting nervous," he says.

### JUST SCRAPING BY

Mr. Bredrick still has his $36.44 monthly Veterans Administration disability payment, $70 a month in food stamps and a temporary housing subsidy that pays nearly all his apartment rent and a portion of his utility bills. But to survive, he says, he has to borrow on his burial-insurance policy and from his elderly mother.

To the dismay of lawmakers in Washington, more and more of their disabled constituents are finding themselves in similar straits. The Senate Finance Committee has scheduled hearings today on bills that could tilt disability-review procedures more in favor of beneficiaries; such legislation already has cleared the House Ways and Means Committee.

A number of those cut off have lost their homes, and advocates for the disabled say that some have committed suicide. Needless to say, such fates aren't what Congress contemplated two years ago when it ordered the Social Security Administration to review most of the disability cases on its rolls every three years. The prevailing sentiment then was that many able-bodied claimants were taking disability-insurance program for a ride.

The mandate for stepped-up reviews jibed with the budget-trimming objectives of the Reagan administration. Citing data suggesting that as much as $4 billion of the nearly $18 billion disbursed to 4.5 million disabled workers and their dependents last year was paid out in error, Social Security Commissioner John Svahn has given priority to disability reviews.

For the current fiscal year, his agency plans to send the federally financed state agencies that operate under its direction 567,000 disability cases for review; that would be more than twice last year's total. For the year beginning Oct. 1, a quota of 804,000 reviews is anticipated.

The reviews made so far may indeed be weeding the able-bodied from the program as Congress intended. Since the review speedup began in March 1981, state offices have cut off about half the reevaluated beneficiaries—or some 175,000 persons. And half of those affected are acceding to the cutoffs.

### VICTIMS OF THE SYSTEM

However, there is evidence that many of the individuals crossed off the rolls by state reviewers truly are disabled. Of the half who appeal the termination of benefits, nearly three-fifths are being found by Social Security's own administrative law judges to be eligible for reinstatement. These people appear to have been victims of complicated guidelines and review procedures that fail to appreciate their true physical conditions and medical histories.

Adding to the controversy over the cutoffs has been the Social Security Administration's intensified effort to influence the most generous law judges to make "correct" decisions in other words fewer decisions in favor of claimants. Increasingly, too, the law judges are being overruled by the SSA Appeals Council in Arlington, Va., which operates as something of a policy organ for the agency and its parent, the Department of Health and Human Services.

Until recently, the appeals council was reviewing every one of the disability decisions made by the three law judges based in Fort Smith. Normally, the council looks at only about 12 percent of law judges' decisions, but the Fort Smith office was put under special scrutiny last August because the law judges had been reinstating benefits in 80 percent of the cases in which they had been cut off by the state. The Fort Smith reinstatement rate was the highest in the nation. During the appeals council review, about 30 percent of the Fort Smith benefit reinstatements were then denied or sent back here for further consideration. The local office now is down to eighth place in reinstatements, with only a 65 percent rate. The law judges here say that they haven't consciously altered their decisionmaking approach and that the drop could be a statistical fluke.

As the SSA sees it, state reviewers err only 3 percent of the time, and those of the agency's 730 administrative law judges with high reversal records tend to be the ones who make the most mistakes.

### A BRIEF FOR BENEFICIARIES

Critics of SSA policies see it differently. The most generous law judges are treated as "scapegoats" and state termination rulings are "clearly erroneous" more than 90 percent of the time, asserts Jonathan Stein, a Philadelphia lawyer representing low-income and disabled clients in a federal-court suit against the disability review procedures.

Wherever the truth lies, termination of disability benefits clearly is becoming an issue in Washington. The legislation approved by the House Ways and Means Committee and generally backed by the Reagan administration would make the appeals process somewhat easier for disability recipients. Face-to-face meetings between claimants and state reviewers would be allowed, for example. Under current practice, state examiners must base their decisions solely on medical reports and other written evidence. Not until a case reaches a law judge does anyone in the review system have an opportunity to form firsthand opinions about a claimant's physical and mental condition.

Politicians in both parties appear eager to further liberalize the Ways and Means bill. One is Rep. John Hammerschmidt, the conservative GOP congressmen from this Western Arkansas district. His local office has been active in behalf of cutoff disability claimants. He and Democratic Rep. Michael Synar from the neighboring Oklahoma district intend to cosponsor amendments to freeze the number of annual reviews at current levels. That would be sufficient to achieve more than 90 percent of the economies possible, House aides say.

In the Senate, Republican William Cohen of Maine and Democrat Carl Levin of Michigan have offered their own disability bill. It would shift the burden of proof for discontinuing benefits to the government from the recipient and would continue payments while appeals to law judges are pending. Republican Sen. John Heinz of Pennsylvania, the chairman of the Senate Aging Committee, is pushing similar legislation as well as a six-month moratorium on most disability reviews.

The periodic investigations currently required of individuals with nonpermanent disabilties "unfortunately . . . have created chaos and inflicted pain that Congress neither envisioned nor desired," Sen. Cohen says.

Rep. Hammerschmidt blames the rapid buildup of review cases for "outrageous" error rates of state examiners who have decided against claimants. Clearly, the workload for many state offices has exploded. Herbert Brown, Tennessee's disability determination head, recently told a Senate hearing that his agency is handling an almost 300 percent increase in disability reviews with only 25 percent more personnel. For a while, heavy overtime left his subordinates "burned out, just trying to survive," he testified.

SSA officials say they have been making things easier on the states by improving the way cases are chosen for review. And the Arkansas chief of disability review, Kenneth Patton, reports his staff isn't having too much trouble these days keeping up with its expanded reviews.

But Mr. Patton does acknowledge that the review process can work to the claimant's disadvantage. Often, for example, those under review may lack the opportunity or the time to present the state office with medical evidence that could help their cases. That is apparently what happened to Mr. Bredrick, the man with the breathing problems.

Last January, he was advised by the Arkansas agency that he had become "able to do substantial gainful work in November 1981." The finding was based on medical records that presumably included the results of a physical examination at a Fort Smith hospital paid for by the state agency.

In his appeal to an administrative law judge, however, the disabled mechanic presented his Veterans Administration hospital treatment record documenting breathing difficulties dating to 1975—a medical history the state office may not have considered. (Mr. Patton, the head of Arkansas disability evaluation, declines to discuss specific cases.) Mr. Bredrick produced evidence that he had had to spend three weeks undergoing hospital drug therapy before he was physically able to attempt a treadmill test.

Frequently, the administrative law judges follow disability standards quite unlike those used by state offices under SSA guidelines. Since the mid-1970s, these guidelines have grown increasingly restrictive on such issues as pain assessment and the weight to be given information supplied by the claimant's physician. The law judges commonly are guided by more lenient federal appeals-court interpretations of disability law.

In the case of Mr. Harper, the nursing home resident, the state disability office had paid for three separate evaluations—by a psychiatrist, a psychologist and a general practitioner. But administrative law judge David Hubbard here felt it wasn't even necessary to see Mr. Harper in person to decide that the decision to cut off his $228-a-month disability check was mistaken.

The law judge was influenced in part by a letter from Mr. Harper's doctor asserting that left to his own devices, Mr. Harper "would not care for his personal safety, hygiene, personal needs, cleanliness, self-medication or appearance."

In Mrs. Anderson's case several physicians asserted that her constant back pain and related problems rendered her incapable of work. She was even able to offer in evidence the conclusions of the Fort Smith orthopedic surgeon who had been retained by the state disability office to examine her. "From an employability standpoint," he stated in his report to the state agency, "I think that this patient is totally disabled."

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[From the Wall Street Journal, May 21, 1982]

## GETTING THE BIRD

Bureaucracy-spoofer James Boren will award his Order of the Bird to a Social Security official who ruled a Vietnam veteran no longer eligible for disability benefits despite a jaw wired shut and loss of a leg, two fingers, his spleen and parts of his stomach and buttocks. The man can work—and "that's how our rules are," according to the official.

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[From the Philadelphia Inquirer, May 21, 1982]

## TASK FORCE: DISABILITY AGENCY NOT "RESPONSIVE"

(By Mary Bishop)

The Pennsylvania agency that determines eligibility for Social Security disability benefits has not been mindful of the "humanistic problems" involved in doing the job, a state task force has concluded.

A February report of the task force commissioned by the Office of Vocational Rehabilitation found that its Bureau of Disability Determination (BDD) is "not responsive to the questions, concerns, and problems" of those who receive benefits.

From the time a person files a claim at a local Social Security office to the time he or she is notified of a decision, the system is "not structured to handle claimant complaints," said the report, a copy of which was obtained by The Inquirer this week.

The report comes amid a national controversy over extensive cuts in the rolls of disability-benefit recipients and the Social Security Administration system's for reviewing eligibility.

"We want to make the process more humane. The way it is now is dehumanizing." said Nick Frasko, the admininistrator of state vocational rehabilitation for the Johnstown area and chairman of the task force.

John DelPaine, director of the BDD, said yesterday that most of the task force's recommendations, including one that the BDD make telephone contact with people who file for disability, would be implemented in three to six months.

The way the system is set up, the three BDD offices, in Wilkes-Barre, Harrisburg and Greensburg, near Altoona, make their decisions primarily on the basis of medical documents and rarely talk to the disability recipients, several state officials said yesterday.

And, partly because of their workload, the offices work slowly, the task force found in January, the BDD's record in processing Supplemental Securtity Income and Social Security Disability Insurance claims was almost 1½ times what its goal was.

Furthermore, the report stated, the BDD's letters to claimants are not easy to understand, do not explain the dramatic changes in disability standards and tend to discourage people from calling the agency with questions.

Many people are puzzled and distressed when they receive notice that their benefits will be cut off, the report pointed out. "These people were not expecting to be re-evaluated and, in some cases, have been receiving benefits for more than 10 years." it said.

In 1980, during the Carter administration, Congress ordered more reviews of disability cases after the General Accounting Office found that as many as a fifth of the disability recipients might be ineligible for the payments.

This year, the Social Security Administration is reviewing a record 550,000 cases across the country, in what some critics say is an overzealous effort by the Reagan administration to reduce the disability rolls. About 45 percent of the reviews are resulting in the cutoff of benefits.

The task force's lengthy report, commissioned by George C. Lowe, executive director of the office of Vocational Rehabilitation after he received many complaints about the disability system, questioned whether the rigorous adherence to regulations in trimming the disability rolls was in keeping with Congress' intent in 1980.

"Our concern centers on those allowed beneficiaries who, in many instances, have been receiving disability benefits for many years and now are being terminated due to a redefinition of the medical listings," the report said.

"Did Congress intend that people who no longer have a meaningful work history be terminated and subjected to the job market without some special set of vocational guidelines first being applied to their individual circumstances?"

Frasko said yesterday that Congress should address this issue soon. "Did they really intend to re-examine people who are 62 years old?" he asked.

The task force seemed to look with some favor on the high rate of reversals of disability cutoffs by Admintrative Law Judges (AJLs). While the state agencies make their decisions strictly on objective information, the AJLs have been allowed to apply more subjective judgments about claimants' problems.

"Perhaps they're right to consider [that] more than just a strict interpretation of the medical listings should be applied to the adjudication precess," the report said of the AJLs.

In other findings, the task force reported that the state's system for medical examinations of people who claim to be disabled does not adequately inform examining doctors of the kind of information they are supposed to provide about the applicants.

It cites the case of one medical group that conducted disability examinations at seven Pennsylvania sites until complaints led the state to suspend its operations last fall.

According to the task force, people complained that the group's doctors spent as little as 10 minutes with them and that staff members "manhandled" them and treated them in a "most discourteous manner."

In examining 67 medical reports on disability recipients from the group, the task force found that the group's use of word-processing equipment limited the reports to a few "set" phrases, providing insufficient information about the person.

Three other medical groups that specialize in disability examinations in Pennsylvania were found to be adequate by task force members when they visited the groups last fall.

The task force recommended that a panel of medical experts review the qualifications of doctors who do the disability examinations, each of which earns them $35 from the state.

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